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ABSTRACT

The information in this book came from a Canadian survey of people with disabilities, along with interviews and focus group discussions with service providers, police, advocates, and family members (total n=120) and a review of the literature, case law, and statutes. The study focused on violent or abusive circumstances experienced by individuals with disabilities and the impact of those acts on their lives. Factors that can contribute to violence and abuse are identified, including negative social stereotypes concerning disability and having caregivers who may lack adequate training or support. Types of violence and abuse identified by persons with disabilities included: physical violence; denial of rights, necessities, privileges, and opportunities; verbal and emotional abuse; and failure to respond to their complaints of abuse and violence. Also considered are: issues of disclosure and identifying violence and abuse; responses after the problem has been identified; Canadian federal, provincial, and territorial legislative responses to violence against persons with disabilities; and analysis of selected case laws. Recommendations are offered for: policy and program reform, statutory reform, providing information to concerned parties and the public about the abuse issue, increased support from the community, and research to obtain relevant data. Appended are statistical survey results and a discussion of the survey methodology. (Contains 270 references.) (SW)

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Harm's WAY:

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The Many Faces of Violence and Abuse Against Persons with Disabilities

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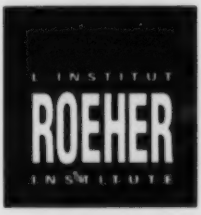

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Foreword

For people with disabilities, life presents substantial challenges — challenges that result not from the disability, but from the accompanying marginalization, discrimination, disregard and neglect of the appalling social and economic conditions they face in society. As a group, people with disabilities are the poorest in society — about half of them have total annual incomes of less than $10,000. Their employment opportunities are far less than others — only about half of them are employed, and the majority of those at entry level jobs. Access to educational opportunities is also limited if the levels of education achieved are a valid indicator. The disproportionate disadvantage of people with disabilities is well documented both in our own work at l'Institut Roeher Institute and in the work of others concerned with disability.

The poverty of people with disabilities means that they may lack the resources — let alone the physical ability — to leave abusive situations. Some people have no idea about their right not to be treated in abusive ways. Many are taught to be passive and compliant to make the care-giving task easier, also making the process of victimization easier. Many have developed low self-esteem as a result of social messages about their worth as human beings. Many people with disabilities are isolated and segregated in institutional settings. Many are dependent on others for help with — and as a result lack control over — the most basic of daily living activities such as moving about, eating, bathing and going to the washroom. Some people are unable to communicate in traditional ways. Care-givers are often over-worked and frustrated, lacking sufficient resources and time to provide proper care.

A consequence of disadvantage is that issues affecting this group of people — issues that should be evident and would be for other people — are overlooked or ignored. This is not necessarily a deliberate action but likely just the result of a failure to be sensitive to those who have traditionally been excluded. Although violence and abuse in general have burgeoned into areas of concern in social policy and government spending and programs, only a very few studies have investigated the incidence of violence and abuse among people with disabilities. And although these studies provided some striking and, indeed, frightening results about the vulnerability of people with disabilities to abuse and violence, they also raised questions.

Somehow the stories we were hearing did not seem to be reflected in the studies we were reading. And the safeguards and precautions that we would have expected in situations of high vulnerability were not only non-existent but were not even identified as needed. It was reminiscent of the silence that surrounded violence against women in the home long after it ought to have been evident.

The reasons behind the silence and the indifference to the circumstances of people with disabilities prompted this study. As we reviewed the literature and conducted preliminary interviews with people with disabilities, it was evident that not only were traditional assaults and abuse not being investigated and resolved but that another whole area of investigation needed to be addressed. We could not find information on how people with disabilities themselves characterized abuse. In other words, as with so many aspects of their lives, in this area the experiences of people with disabilities were being appropriated and interpreted from the perspective of others.

This study was an effort to give people with disabilities a voice in naming violence and abuse. It provided an opportunity for speaking of their own experiences and of those events and actions that are abusive from their perspective. People with a

variety of disabilities from across the country were interviewed in depth. They were given an opportunity to tell their stories. They were given an opportunity to say how various violent or abusive actions affected them, how the acts made them feel, how such acts had an impact on their lives and their self-esteem, and how these acts created a susceptibility to further acts of violence. The entire culture of lack of confidence and control, isolation and desire for human contact and affection and lack of a sense of self-worth emerges in the chorus of voices and words.

From that perspective, violence and abuse look somewhat different. In the experience of those with disabilities, it is not only the traditional acts of hitting, sexually assaulting or verbally abusing a person that are being defined as violent. It is, in fact, a wide gamut of actions or lack of actions that create suffering or trauma. It is being pulled into an uncomfortable position. It is being isolated at home and not being allowed to go to school. It is being forced to eat or being denied food. It is being given medication that takes away one's sense of control. It is being left sitting on a toilet for long periods of time.

We feel it is crucial that the silence be broken and the entire structure of violence and abuse be exposed. Only in this way can it be addressed. Measures to reduce vulnerability and to create more control for individuals and more accountability in the service sector must be a result of this exposure. Measures to give support to people in their right to be safe from such violence and to expose perpetrators must be made. Further measures to improve access to the justice system and supports to help them see justice done must be put in place.

All this is crucial so people with disabilities will no longer be seen as easy targets of violent acts or abusive treatment, as people who have no one to tell, who are physically or emotionally unable to tell or who will not be believed when they tell. Action is crucial so people can live as equal, fully participating members of their communities, free from the threat of violence and abuse.

There are many people to thank at the conclusion of such an undertaking. Thanks go out to the people who conducted the interviews: Helen Simson, Anne George, Janet Morrell, Nancy E. Hansen, Jean-François Martin, Miriam Ticoll and Melanie Panitch. They created a safe, empathetic environment for people to disclose — and sometimes relive — often painful experiences. Special thanks go out to the hundreds of people who offered their personal stories as a means of exposing and ending the violence and abuse against vulnerable people such as themselves, and to the people who offered valuable information about weaknesses in the legal system and in response programs. We are also grateful to the many people across the country who helped in finding interview subjects. Thanks are extended to Fred Mathews, Sandra Carpenter, Anne George, Miriam Ticoll, Melanie Panitch and Melanie Rock, who gave valuable input during the process of synthesizing this incredible amount of information into a cohesive document.

We would particularly like to thank the Family Violence Prevention Division of Health Canada, the Women's Program of Human Resources Development Canada and the Status of Disabled Persons Secretariat of Human Resources Development Canada for funding the project. Without their awareness that violence and abuse against persons with disabilities are serious, insidious problems that need first to be fully defined and, second, addressed, this research would not have been possible.

It is hoped that this study will begin a dialogue on the many, as yet not fully recognized, ways that people with disabilities experience violence and abuse, and that the dialogue will lead to concrete measures to halt this untenable situation.

Marcia H. Rioux, PhD
Executive Director

Introduction

> Violence is a result of our so-called "idea" of where people fit in the hierarchy. These people [people with disabilities] are at the bottom. Consequently, doing violence to them isn't a big issue because they're not worth anything anyway. ... We live in a violent society. And people who for one reason or another are unable to assert their own needs or their rights, or protect themselves — many of whom have a disabling condition — are susceptible to violence. Except they can't run away. They don't have any place else to go. Police don't necessarily listen to them, so the institutions that are supposedly there to protect us simply don't pay attention. ... So protection must come from their own efforts. And if they can't mobilize their own resources, or if there are no resources to mobilize, there's nothing anyone can do.

These words of an individual who was interviewed for this research study capture themes that surfaced on many occasions throughout the course of the research. There is a constant threat of violence and abuse in the lives of many people with disabilities. For many people, an inferior social standing and a sense of worthlessness are synonymous with the phrase *persons with disabilities*. There is society's seemingly indifferent acceptance of violence and abuse against people with disabilities and the sense that it is *their* problem, not *ours*, if indeed there is a problem at all. There is the difficulty that victims face in attempting to assert themselves against violent people and abusive situations. There is the inability of victims to escape to safer situations. The apparent incapacity of our social institutions to deal with this problem surfaces as another theme, as does the powerlessness of people with disabilities to transform the dangerous circumstances in which they find themselves. Finally, there is even a sense of hopelessness that anything will ever change for the better — that the problem is just too big and out of control.

It has become clear that the way people with disabilities name abuse and violence in their lives differs from how the problem is defined in relation to other vulnerable groups such as children, women, Aboriginal people and senior citizens. Moreover, the harms that people with disabilities are experiencing do not seem to fit entirely within conventional *Criminal Code*, civil code and research definitions. If people with disabilities are living in situations that they experience as violent or abusive, and if society does not understand how and why this is occurring, then society is not in a position to address the problem. Nor can society ameliorate the problem if it does not recognize the particular actions and situations that people with disabilities perceive as violent or abusive.

What are the particular forms of violence and abuse experienced by people with disabilities? What words do people use to describe the problem and how does this compare with the ways the problem has been framed in research, law, public policy and social programming? How widely are violence and abuse occurring? What are the causes of violence and the conditions that place people with disabilities at risk? What factors make some individuals more vulnerable than others? What factors hinder survivors from coming forward and why is detection obscured? How do others — individuals and systems — respond once the problem has been identified? What parts do social policy, laws and our courts play in stemming the problem — or in allowing it to continue? What needs to happen to reduce violence and abuse against people with disabilities and to increase effective responses to victims? These questions have guided the study.

Information for this study came from many sources: an extensive literature review; a review of case law and federal and provincial statutes; interviews with persons with disabilities, most of whom had been victimized; and interviews

and focus groups with service providers, police, advocates and family members of persons with disabilities. There is an appendix on methodology at the end of the report.

The terms *violence* and *abuse* are used somewhat interchangeably throughout this report. It is recognized that the notion of violence often implies some level of unwanted force or physical injury, whereas abuse can be understood to involve forms of exploitation that may not involve physical force or injuries perceptible to the harmed person. However, when interview respondents with disabilities were asked about the kinds of *harms* they had experienced as violent, they tended to blur the lines between the notions of violence and abuse. This ambiguity is reflected in some of the research literature, as well as in legal and policy instruments dealing with the problem. Therefore, no effort has been made in this research to create an objective boundary between the two notions.

The term *survivor* in the report refers to individuals who were interviewed who are coming to terms with the violence and abuse against themselves and whose healing process is well under way. However, the term also refers to respondents who are experiencing great difficulty facing what has happened to them and who are still devastated, years after the fact.

The term *victim* is intended to mean the person who is subjected to violent or abusive acts or circumstances. *Victimization* connotes simply the process by which a perpetrator or a set of conditions subjects a person to abuse, violence or harm.

The study is based on the principle that violent and abusive acts and situations are no more acceptable when they harm persons with disabilities than when they harm other individuals or groups of persons. Actions and situations that are violent and abusive conflict with the most basic human rights that should be accorded to all citizens: to live in safety and security, respected and equal in society.

Chapter 1. Traditional Approaches to the Problem

Relatively few research studies have examined the nature and extent of violence and abuse against persons with disabilities. Past research tends to look at the problem from the standpoint of conventional categories, such as sexual abuse and sexual and physical assaults. Such an approach to violence roughly mirrors the operative definition that is embedded in the criminal law concerning serious offences. Although people with disabilities do experience violence and abuse in these forms, many other acts to which they are particularly susceptible and which they may depict as acts of violence have not received much attention in past research. Therefore, it is difficult to estimate how widely such acts occur. These acts include:

- the various ways in which care is distorted into acts of malevolence or acts that compromise physical or psychological well-being while retaining the outward form of treatment or care;[1]
- acts which deny people with disabilities family life (e.g., children apprehended by state authorities or pressure not to conceive);
- specific acts and circumstances that effectively compromise the economic security of people with disabilities;[2]

- acts by which ordinary conditions for physical and mental well-being are denied, such as refusal of decent housing, refusal of assistance with personal care or mobility and denial of other goods and services perceived as important by persons with disabilities (e.g., emotional or psychiatric counselling, disability-related medications, money for daily living);[3]

- acts by which social interaction and inclusion are denied, including the obstruction of communication and restriction of participation in social activities;

- acts by which ordinary freedoms are denied;

- patterns of communication that are perceived as forms of threat, insult or harassment.[4]

These faces of violence and abuse are examined in more detail in Chapter 3.

Adding to the challenge of understanding violence and abuse against persons with disabilities is the fact that research studies in the fields of sociology, criminology and psychology have been based on small samples. This makes it difficult to generalize with confidence about the extent of the problem even when measured by conventional standards.[5] Moreover, much of the research is American. Given the prevalence of firearms in the United States, the profile of violence in that country is different than in Canada. In addition, legal provisions, social policy and social programs differ on both sides of the border, which may result in different conditions of risk and abuse for persons with disabilities in Canada.

Several large sources of Canadian research data are at the present time unable to shed light on violence and abuse against persons with disabilities. The data is not organized in a way that allows for the systematic gathering, retrieval and analysis

of this kind of information. For example, national crime statistics provided by police departments to Statistics Canada concerning complaints, arrests and convictions have not been classified according to whether the survivors have disabilities. This data does not, therefore, reveal the extent to which various actions proscribed by the federal *Criminal Code* are occurring in the lives of persons with disabilities. This limitation stems in part from the structure of Statistics Canada's Unified Crime Report format, which drives police data gathering and reporting for statistical purposes. As a result, few police departments have the means to systematically input and extract data from crime incident reports that relates to persons with disabilities; few departments have set about to collect this data by other means.

Research into patterns of criminal victimization based on large interview samples, such as Statistics Canada's General Social Survey on personal risk, until recently did not include questions about whether crime victims have disabilities. The electronic data for the Statistics Canada survey entered the public domain too late for analysis and inclusion in this report and the recent publication arising from the data does not refer to persons with disabilities. Moreover, the measurement of violence is again limited to actions that are prohibited under the federal *Criminal Code*.[6]

Large databases with a specific focus on persons with disabilities, such as Statistics Canada's Health and Activity Limitation Survey (HALS), provide data on whether respondents' particular disabilities were caused by violence but not whether respondents with disabilities have been victimized since the onset of disability. The HALS household and institutional surveys could include questions on this issue and the survey instrument could also be modified to identify more clearly particular situations that respondents with disabilities find abusive or violent.

Another difficulty in assessing the nature and scope of violence and abuse against persons with disabilities are contradictory research findings. For example, Westcott (1991) and The Roeher Institute (1988c) have found that children with disabilities are at a high risk of abuse as compared with other children. However, Benedict et al. (1990) found no such correlation between disability and victimization.

There are positive signs, however, that attention in the research community is beginning to shift towards violence and abuse against persons with disabilities. Statistics Canada, for example, in its recent survey on assault and sexual assault against women, collected raw data on female abuse survivors who have ongoing health problems that affect their daily activities. The data indicate that adult women aged 16 years and over with a disability or disabling health problem[7] are considerably more likely than females without such limitations to be physically or sexually assaulted by their partners over the course of their married lives (39 as compared with 29 per cent).[8] Examining the extent to which women in Canada have ever in their adult lives (i.e., since the age of 16) experienced one or more forms of assault or sexual assault as proscribed by the current *Criminal Code*,[9] this survey indicates that women with disabilities are more likely than women without disabilities to be subjected to violence of some kind: 60 per cent compared to 50 per cent.[10] However, no other research and analysis concerning the victimization of women with disabilities have yet been conducted on the basis of this survey data.[11]

Although the current state of research provides only limited insight into the extent and dimensions of violence and abuse against persons with disabilities, it is nonetheless illuminating. The sheer accumulation of independent findings strongly suggests that, even when looked at from the perspective of conventional measures of violence and abuse, there is a problem of considerable magnitude. The following tables show other researchers' findings concerning the extent of sexual and physical assaults.[12]

Table 1. Violence and abuse against women with disabilities

Have been assaulted, sexually assaulted or abused	Will be sexually assaulted in their lifetime
40%	83%
Source: Stimpson and Best, 1991	

Table 2. Sexual abuse of children

Girls		Boys	
Hearing 25%	Deaf 50%	Hearing 10%	Deaf 54%
Source: Sullivan, Vernon and Scanlan, 1987			

Table 3. Psychiatric patients victimized by major physical or sexual assault

Psychiatric outpatients	Psychiatric inpatients
68%	81%
Source: Jacobson, 1989	Source: Jacobson and Richardson, 1987

Table 4. Violence and abuse against children with multiple disabilities admitted to a psychiatric hospital

All sampled:	Sub-sample of children who had been sexually abused:
39% suffered maltreatment (mainly physical abuse)	40% abused by more than one perpetrator
Source: Ammerman, Lubetsky et al., 1988	

Table 5. Violence and abuse against residents of a psychiatric institution

Threatened with violence within the institution	Assaulted		Sexually assaulted	
	By staff	By other residents	By staff	By other residents
71%	39%	53%	27%	55%
Source: Nibert et al., 1989				

Table 6. Physical or sexual assault of ever-married females by their partners

Females without disabilities	Females with disabilities
29% have been physically or sexually assaulted by their partners	39% have been physically or sexually assaulted by their partners
	74% have experienced physical violence
	38% have experienced sexual violence
Source: Statistics Canada, Centre for Justice Statistics, 1994c	

Table 7. Other physical abuses

Nurses and aides in nursing and intermediate care facilities who were interviewed	Consumers of attendant care services
10% admitted to physically abusing clients	10% have been physically abused by attendant care providers
Source: Pillemar and Moore, 1990	Source: Ulicny et al., 1990

Notes

1. Hoefkens and Allen (1990) found that 56 per cent of individuals who were admitted to a hospital-based unit for persons with intellectual disabilities received anti-psychotic drug treatment without diagnosis of psychosis or related disorders that would normally be required to justify such treatment.

2. A number of studies have looked at the social and policy determinants of poverty and unemployment of persons with disabilities. However, such studies have not explicitly framed such issues as ones of violence and abuse, although such an inference could certainly be drawn. See for example The Roeher Institute 1992c and 1990.

3. Ulicny et al. (1990) found that 40 per cent of consumers of attendant services have encountered theft by attendants as a form of abuse.

4. Pillemar and Moore (1990) found that 40 per cent of the nurses and nurses aides in nursing and intermediate care facilities who were interviewed for their research admitted to engaging in the psychological abuse of clients. The Canadian Mental Health Association (1993) found that 90 per cent of research respondents with psychiatric disabilities who indicate that they have experienced violence in the community have experienced verbal or emotional violence.

5. Some researchers have estimated that persons with disabilities are about one-and-one-half times more likely to encounter violence against themselves than the population at large. (Sobsey, 1994; Crosse et al., 1993; see also The McCreary Centre Society, 1993, pp. 5-6.)

6. The structure of the survey instrument also makes it difficult to differentiate between violence that occurs in prisons and violence that occurs in other institutional settings, such as rehabilitation facilities or hospitals. Patterns of violence at these various sites are likely to be different and persons with disabilities are more likely than others to be involved with hospitals and rehabilitation facilities. It would make more sense for the survey questionnaire not to lump together all institutions as if they are equivalent in terms of risks and harms that they present to their residents.

7. At the time this report was prepared, Statistics Canada had not completed classifying respondents' particular disabilities. All that is known is that the respondents have some kind of condition or health problem that limits their daily activities.

8. Statistics Canada, Canadian Centre for Justice Statistics, 1994c, p. 6. The survey, however, does not clarify whether respondents sustained their disabilities as a result of the abuse or before or after the abuse as a result of other factors such as auto accidents or work injuries.

9. That is, the respondents experienced violence regardless of whether it was perpetrated by their husbands or male partners.

10. The Canadian Centre for Justice Statistics provided a special cross-tabulation to l'Institut Roeher Institute on this issue.

11. Because of the difficulties encountered in classifying respondents' disabilities, the data set was not available when this report was prepared.

12. Sources for the tables are cited fully in the Bibliography.

Chapter 2. Precipitating Factors and Demographics of Risk

Many people with disabilities have to contend with a myriad of factors that can increase the chances of violence and abuse against them and take a toll on their self-esteem and self-confidence. These factors include: negative social stereotypes and attitudes concerning disability in a society that prizes physical perfection and intelligence; having to depend on others in a society that values independence; being in situations where care-givers may lack adequate training or support and therefore are frustrated, stressed or insensitive; being poor or economically dependent on others in a society that values wealth; being socially isolated and therefore having limited social networks, few close friendships and few perceived alternatives to abusive situations; being denied control in a society that values power and control; and being socialized in ways that leave one unprepared for the risks of adult life. In the words of one respondent, "People may internalize [this] social devaluation, believing that they are not entitled to respect and dignity." In the words of another, "We tend to blame ourselves for whatever happens."

Given the context, it is hardly surprising that, as one respondent indicated, "A sense of personal imperfection ... can make sexual attentions which appear inappropriate, abusive or exploitive to professionals appear in some ways positive." Several respondents felt that people with disabilities who have been victimized sometimes find ways to accept abusive situations because they fear that the alternative would be no support or sense of belonging whatsoever.

The following analysis examines conditions of vulnerability regardless of the places where victimization occurs. This approach has been adopted because, as one respondent pointed out, people with disabilities are vulnerable "everywhere. All the time". Indeed, respondents indicated that violence occurs in places of residence such as private dwellings, group homes and boarding houses. Violence occurs in many other places including institutional settings such as schools, nursing homes, hospitals, mental health treatment facilities and sheltered workshops. Violence and abuse also occur on buses and subways, in taxi cabs, ambulances, private automobiles, public swimming pools, malls and the streets. Given the diversity of places where people with disabilities may be vulnerable to violence, the analysis focuses on factors associated with risk that can transform ostensibly safe or innocuous places into situations of harm (The McCreary Centre Society, 1993; Westcott, 1993; The Roeher Institute, 1992b; Crossmaker, 1991; The Roeher Institute 1990; Young, 1990; The Roeher Institute, 1988b; Straus, 1988; Garbarino, 1987).

Unless stated otherwise, statistical data used in this chapter are from the 1986 Health and Activity Limitation Survey (HALS). To facilitate reading, much of the statistical detail is provided in the notes rather than in the body of the report. A Statistical Appendix at the end of the report provides detail too lengthy to include in the notes.

Society's Inability to Clearly Name and Prohibit the Problem

Acts that persons with disabilities perceive to be abusive or violent but that are not clearly prohibited by law, social policy, administrative practice or professional training are acts that are likely to continue occurring. For example, the discussion in Chapter 3 shows how some forms of violence and abuse take the outward guise of care. This problem reflects society's acceptance of actions embedded in professional practice that many people with disabilities consider offensive. The responses to violent and abusive actions against persons with disabilities are affected by whether or not such acts are considered unacceptable by families, by service providers in the social, health, educational and counselling sectors, as well as by the criminal justice system.[1] In addition, unclear legal definitions of abuse and violence against persons with disabilities create leeway for such acts to go undetected or to be passed off as trifling complaints.[2] A climate of acceptance, ambiguity and ignorance surrounds abuse and violence against persons with disabilities. This climate, in effect, gives tacit permission to individuals who would act violently and abusively.

The Devaluing and Exploitation of Difference

The devaluing and exploitation of differences such as disability and gender both reflect, and feed into, negative stereotypes that increase the chances that victimization will occur and that people's stories will not be believed.

Negative Stereotypes and Attitudes

It would be simplistic to assert that negative attitudes and stereotypes are the principal reasons why people with disabilities are subjected to violence. Negative stereotypes do, however, contribute to the problem. Particular stereotypes that interviewees believe contribute to violence against people with disabilities are the perceptions that individuals "are stupid and can be taken advantage of", that they "don't know any better", and that they "have no emotions and are more controllable" than others. In the words of one respondent, "They are seen as less valued as human beings — as objects or as children." Another respondent, who felt that people with disabilities are often considered to be "lesser beings", said they are regarded as people "who do not deserve decent treatment". Other stereotypes include the notion that people with disabilities are a burden, "worthless", "passive" and fear-inspiring.[3]

Several respondents felt that society in general views people with disabilities as being asexual. Other respondents felt that people with disabilities are presumed to have no opportunities for sexual relations and are therefore open to whatever sexual advances are made towards them. Either way, respondents believed that society views people with disabilities as tolerant of sexual exploitation. Several respondents also felt that people with disabilities are seen as unlikely to disclose violence. In the words of one individual concerning a potential perpetrator, "He might think that I won't speak up for myself."

Negative societal attitudes and stereotypes are assimilated by some care-givers. Respondents talked about the inability of spouses and friends to accept that the respondents had disabilities and about the denigrating attitudes of family members. Instances of the abuse of young persons with disabilities were identified in which ordinary parental affection and care were lacking.

Concerning paid care-givers, sheer ignorance about, and insensitivity towards, disability were identified by interview respondents as factors contributing to negative attitudes towards clients. The lack of information, sensitivity and training among paid care-givers means that negative stereotypes and attitudes persist in the social service and health fields.

Negative assumptions, stereotypes and ignorance within the criminal justice system, which reflect society's views on disability generally, can reinforce the mistaken notions that persons with disabilities are unattractive and therefore unlikely to be the focus of sexual abuse or are well taken care of in "safe" environments, such as institutions and group homes, where violence and abuses either do not happen or are effectively addressed. Negative perceptions and feelings of awkwardness towards persons with disabilities among the policing community can cause a lack of police involvement with this segment of the population, which compromises the safety of persons with disabilities.

Negative attitudes on the part of strangers were also identified as contributing to violence. Respondents said these attitudes were expressed in taunts, harassment, threats and ultimately assaults in public places. It was also pointed out that individuals who physically remove themselves from the presence of people with disabilities in public places are indicating that persons with disabilities, as a group, inspire fear.

Disability

Many respondents expressed the view that simply having a disability puts people at increased risk of victimization. Several respondents — females included — felt that, although factors such as gender increase the chances that females will be victimized, disability is a more fundamental risk factor. Their feeling was that a person who has a disability is often in social relationships where the other person has more power.

Disability can create vulnerability in many ways. Visual impairment or an intellectual or psychiatric disability may affect a person's ability to discern danger. A mobility or agility impairment can prevent escape from dangerous situations. Speech and hearing impairments and intellectual disabilities that affect language development and communication can make it difficult to report violence to others.

Disability can also contribute to vulnerability indirectly, for example, when a psychiatric condition is used to justify placement of the individual in a treatment setting where victimization occurs. Congregate and segregated care settings, in which victimization can occur, are often presented as the only housing and social service options open to people with physical and intellectual disabilities.

The fact that individuals may have to rely on family members or service providers who may be ill-equipped for the task of care-giving is another indirect cause of vulnerability. Moreover, how society, social services and the criminal justice system are organized in reference to disability can result in social isolation, social stigmatization, poverty, lowered self-esteem, limited opportunities to learn, the absence of personal control in daily living decisions and reduced credibility. In short, factors inherent to having a disability can render persons vulnerable, as can the way in which society is organized with respect to people with disabilities.

Gender

Some respondents considered gender to be a factor that places females with disabilities at particular risk of being victimized. Females' physical size and comparative lack of physical strength were singled out as gender-related factors that render them vulnerable to violence, particularly by male offenders.

As one respondent indicated, "Women are more at risk than men because men are stronger. Men are able to do what they want. Women are not. Some men abuse women and children simply because they are weaker." Clearly, when people are victimized because they are perceived as weaker than others, this reflects an extreme lack of respect for such persons. Economic and other power relations between the sexes were also identified as placing females with disabilities at greater risk than males.

As females are vulnerable in society irrespective of disability, females with disabilities were seen by some respondents as sharing in that vulnerability. In fact, statistics suggest that women with disabilities are at even greater risk than women generally. Statistics Canada has recently found that 39 per cent of ever-married women with a disability or a disabling health problem have reported physical or sexual assault by a partner over the course of their married lives. This is roughly one-third higher than among their non-disabled female counterparts, where the rate is 29 per cent (Statistics Canada, Centre for Justice Statistics, 1994c, p. 6). The Statistics Canada finding is similar to the research findings of Stimpson and Best (1991), who found that 40 per cent of females with disabilities have been assaulted, sexually assaulted or abused. The Roeher Institute (1988c) has found that girls with intellectual disabilities are twice as likely as boys to be sexually abused before the age of 18 years.

Referring to structural inequities that can legitimize abuses and other forms of violence, a respondent with a visual impairment commented, "I have male friends who have decent jobs, who are basically given more of a chance than I feel my women friends have. Why are women discriminated against in the first place? Why don't we get equal pay? Not being given equal chances. Not being respected. I know visually impaired

men who are very well respected — 'Oh! Look! He's visually impaired and look at what he can do!' and visually impaired women are looked at like old spinsters."

Concerning gender-based exploitation, one respondent said, "single disabled women are vulnerable to men who are prone to exploiting their [the women's] needs for male attention and interaction, and who believe they can get away with anything." Echoing this concern, another respondent said, "some men may derive a benefit in terms of their self-esteem by being involved with a disabled woman. It makes the man a good person", despite the fact that he may turn out to be an offender.

Several respondents indicated that the gender of social service providers can place females with disabilities at risk. For example, agencies responsible for providing attendant care services do not always ensure that female attendants are matched with female clients. Several respondents indicated that the risk of sexual and other abuse rises in situations where male attendants assist female clients with intimate personal care. However, it was also pointed out that males with disabilities may be particularly vulnerable to sexual and other abuses from females, who tend to dominate the care-giving professions.

Indeed, although the notion that females with disabilities are at particular risk was widespread among respondents, not all shared this viewpoint. Many were simply unclear about the issue and others did not feel that gender was a key factor. For example, a female respondent commented, "It can happen to anybody, really." One service provider reported, "We've been finding out that it [violence] is pretty equal [across gender] — probably a much higher level of male abuse than in the general male population." Another service provider said this "is a complex question. Women are generally more often sexually abused, but I've dealt with as many male survivors as I have female survivors." A female consumer felt that power imbalance, irrespective of gender, was the real issue.

Other respondents indicated that gender may have a bearing on the kind of violence that occurs, with males being more susceptible than females to physical assault and abuse and females being more susceptible to sexual abuse and sexual assault. A recent report by the Canadian Mental Health Association supports to the view that females with disabilities, specifically with psychiatric disabilities, are more susceptible than males to sexual and emotional violence; however, the report indicates that males and females encounter the same level of physical violence and exploitation (The Canadian Mental Health Association, 1993, p. 9). In the Canadian adult population generally (with and without disabilities), the Centre for Justice Statistics found that males are slightly more likely than females to be victimized by assault (68 per cent compared to 66 per cent in 1993). In contrast, 29 per cent of women were sexually assaulted, whereas the number of sexually assaulted men was statistically too low to report.[4]

Several interview respondents felt that males with disabilities are more vulnerable to sexual abuse than males without disabilities because a high proportion of care providers are female. However, others indicated that males with disabilities are also particularly vulnerable to abuse by other males. Regardless of the gender of perpetrators, Sunny Hill Health Centre for Children in Vancouver, B.C., recently reported that males with disabilities are twice as likely as males without disabilities to be sexually abused in their lifetime (Parton, 1994, p. B-6). As with females, relative lack of physical strength was singled out as a factor that can render males with a disability vulnerable. "Men who are in a weak position will get it too," said one respondent for this research, echoing the view of several others.[5] Nevertheless, it is important to point out that females are generally more likely than males to be subject to a range of conditions that interview respondents have associated with violence.[6] These conditions are discussed further below.

Ethnicity

With few exceptions, interview respondents were generally unclear about whether race and ethnicity are associated with higher risks of victimization. It is also difficult using the HALS statistical data to determine the relationship between race and other factors that place individuals at risk.[7] However, HALS data strongly suggest that a person whose mother tongue is neither English nor French *and* whose ethnic background is neither British nor French is more likely to be in harm's way.[8] These individuals will be referred to as "selected persons with disabilities from ethnocultural minority groups" in the discussion below. The statistical data also indicate that gender may cross with ethnicity and language to place women from ethnocultural minority groups at particular risk.

The selected persons from ethnocultural minority groups are much more likely than other Canadians to have disabilities: 26.8 per cent compared to 14.2 per cent. They are also much more likely to be female: 76.5 per cent compared with 52 per cent. They are more likely than other persons with disabilities to be poor.[9] Of women with disabilities from these ethnocultural minority groups, 90.1 per cent have total annual incomes of less than $10,000.

Among adults with disabilities who require assistance with intimate personal care such as dressing, bathing or using the toilet, individuals from the ethnocultural minority groups are more likely than others to be in situations where they may have to choose between allowing an offender to provide assistance or going without assistance altogether.[10] In particular, 65.4 per cent of women from these groups require more assistance than is available to them. These women are also much more dependent than other women on the goodwill of immediate family, friends and neighbours to provide this assistance.[11]

Persons with disabilities from the ethnocultural minority groups are more likely than others to be socially isolated, never visiting others and never conversing by telephone.[12] Women from these groups are more than one-and-one-half times more likely than other women with disabilities to be socially cut off from others.[13]

Individuals with disabilities from these groups are more likely than others to be very vulnerable to victimization in that 16.2 per cent satisfy all of the following criteria: a) they do not know where to get information concerning their human rights and therefore may not understand their rights or how to make a complaint; b) they require assistance with one or more daily activities and so are reliant on others; c) they have total personal incomes from all sources of less than $15,000 and are, therefore, poor and less able than others to pay for alternative care choices that deliver them from dangerous situations; and d) they have an emotional, psychiatric or intellectual disability and therefore may be seen as less valuable than others, more exploitable or as suitable targets on other grounds. In this sense, only 10.4 per cent of other persons with disabilities are very vulnerable. Some 17.2 per cent of the selected women with disabilities from ethnocultural minority groups are very vulnerable in this sense. The following table shows the distribution of these women and women from such groups who do not have disabilities. The former are much more likely than the latter to be daughters living with one or both parents, female lone parents, women living alone, women living with extended family members or living in collective households such as hotels, motels and rooming or lodging houses.

Finally, the selected persons from ethnocultural minority groups are not as likely as others to be able to tell that they have been victimized;[14] 15.6 per cent of such women are only partially or not at all able to make themselves understood by people other than immediate family and friends.

Table 8. Distribution of two groups of women by living arrangement, showing percentages

	Selected women without disabilities from ethnocultural minority groups (*N*=96,990)	Selected women from ethnocultural minority groups who are *very vulnerable* (*N*=7,540)
Daughter with parent(s)	0.7	3.7
Female lone parent	4.5	16.0
Wife/female common-law partner	70.8	14.8
Other family member	20.3	52.7
Alone	3.5	6.8
Unattached, living with non-relative(s) in private household	0.2	0.6
Collective household member	0.0	5.4

(Source: HALS, 1986)

Limited Credibility

When individuals are viewed in light of negative assumptions about disability, they may find that others doubt their story or blame them for an incident. This increases the chances that they will be victimized and that the victimization will continue unchecked. For example, a male survivor of sexual abuse who was interviewed for this report related how his father initially refused to believe the truth of his son's disclosure, a problem that is by no means limited to this individual and his father. A service provider who was interviewed for the research indicated that service providers and professionals can be prone to thinking that persons with disabilities who disclose incidents of violence against themselves are "exaggerating the facts".

An individual with a speech impairment reported how her complaint had been dismissed out of hand by the police because they thought she was drunk. Another person related that the police asked the boyfriend of a female survivor of sexual assault whether she was lying about the incident. Another respondent commented, "They [the police] never take anyone with a mental handicap seriously. No credibility. No respect." Other respondents corroborated this view concerning police perceptions of the credibility of people with intellectual and psychiatric disabilities in particular. An incident was related where police refused to even take information regarding an alleged incident of violence because they did not feel the complainant was credible.

Although the police were singled out for not believing complainants, at other times respondents portrayed them in a more sympathetic light. For example, a mother of a son with an intellectual disability who had been sexually abused by his father did not feel that the police doubted her son's story. She did say, however, that the police felt their "hands were tied" because, in their view, the son would not make a good witness in court. Indeed, interviewers heard about cases that had been thrown out of court because judges presumed the complainants' intellectual disabilities implied a lack of credibility. One respondent said, "Judges are turning the accused into victims in order to protect the accused." Interviewers also heard about incidents in which defence attorneys exploited stereotypes about complainants' physical disabilities in efforts to undermine the complainants' credibility in court.

People with disabilities often find themselves in situations where they are susceptible to being victimized. That they may not be taken seriously when disclosing incidents can only serve as further inducement to would-be perpetrators.

Unequal Social and Economic Positions of Persons with Disabilities

People with disabilities are at a significant disadvantage in society. Many of the social and economic conditions they face were perceived by interview respondents as abusive in themselves, while other conditions increase the likelihood of victimization. These conditions reflect a basic lack of equality that is associated with abuse and violence.

Poverty and Economic Dependency

Generally speaking, people with disabilities are poor.[15] One respondent reflected on the economic circumstances of people she knows: "People are forced somehow to work for less than minimum wage. There is a place downtown where I think they are only getting about three dollars. They're taking advantage of us — pay the lowest part and squeeze as much work as they can." Clearly, in the absence of more adequate financing arrangements, individuals lack the financial means to escape abusive circumstances or, in the words of one respondent, "to access commodities and services that can make you safe". Female lone parents with disabilities and individuals with disabilities who are living alone or with others (excluding family members) in private households are particularly likely to live below Statistics Canada's "low income cut-off".[16]

As one respondent indicated, poverty contributes to victimization in that "being on social assistance limits where you can go, where you can live, who you meet, what types of resources you can access."[17] One individual who was abused and who subsequently put himself in situations where he was likely to be re-victimized, said, "I go to that person's place because he gives me something to eat. Pathetic isn't it?"

Because they are often poor, persons with disabilities may be more likely to live in low income districts where crime rates are comparatively high. Statistical data on this issue are scarce. However, a recent statistical report by the Hamilton-Wentworth police department indicates that people with disabilities are more likely than others to be in situations where they are concerned about crime and other risks to their personal safety (cited in The Roeher Institute, 1993a, p. 35).

Poverty was also cited as a factor that lowers self-esteem. Low self-esteem, in turn, was presented as yet another condition that places individuals with disabilities at risk of being victimized. A respondent pointed out, "Poverty and being on social assistance endows people with negative qualities — a 'tacky welfare person' who has no social value and who is a burden." The implication is that society tends to look the other way when such persons are victimized.

The economic dependency of persons with disabilities on care-givers is another factor that interview respondents associated with victimization. In these circumstances, the abused persons perceive that they lack the financial means to move away from abusive situations. For example, a respondent who felt she had been routinely abused by her husband said, "If I had a disability pension that was just for me and better transportation I wouldn't be so dependent on others and my husband."[18] Other respondents indicated that their lack of financial resources in effect kept them captive to non-family situations in which the costs of care were covered but where they were being abused (e.g., abusive special care or group home settings). Low income is also associated with increased frequency of hospitalization, which increases the chances of victimization by hospital personnel.[19]

Reliance on Others for Disability-related Needs

Another critical factor that interview respondents identified as contributing to violence against persons with disabilities is their reliance on others for assistance with personal care and other daily activities. A respondent said, "The more dependent they are on others [the] ... more at risk."[20]

Reliance on others is an inescapable fact of life for many people with disabilities. According to HALS, 1986, 1.6 million adults with disabilities, because of their condition, require assistance from others with one or more daily living activities such as shopping, meal preparation, financial management, transportation, personal care and mobility. There are 384,110 individuals requiring assistance with personal finances; 184,550 receive assistance from others for intimate personal care such as using the toilet, dressing and bathing; 28,204 require assistance from others to move about within their own residences. Some 67.7 per cent of these persons need more assistance than is available to them.

The more often an individual is exposed to others in these ways, the greater the odds they will be harmed. A respondent said, "Personal care is the big, big deal. If somebody has been bathed or requires a staff to be in the washroom while they're bathing or going to the bathroom, that opens up [the situation] to abuse far more often than it does for somebody who doesn't need that level of care." There are 14,720 adults with disabilities receiving daily assistance with intimate personal care from people other than immediate family members, friends and neighbours.

The large number of care providers and high staff turnover in some residential care environments were flagged as other factors associated with violence. Respondents considered that the chances of being victimized increase with the ever-growing number of persons who are at some point involved in the intimate details of one's life.

The failure of care-givers to provide needed support was also portrayed by several respondents as a form of abuse. In some cases, the withholding of support was deliberate and with malicious intent. In other situations, supports were simply not available or were inadequate to meet a person's needs. Of the 184,550 persons who receive assistance with personal care, 47 per cent require more assistance than is available to them. Some 30,000 persons require assistance with intimate personal care and receive none. For a more detailed discussion see Chapter 3.

Social Isolation

People with disabilities sometimes experience social isolation as a form of abuse, especially when care-givers use it as a means of control or punishment. However, isolation was also presented as a social condition that contributes to other forms of victimization. The reliance of persons with disabilities on others for support often happens within a wider context of social isolation. When people are socially isolated, the ordinary social checks and balances that can discourage, detect and address violence are not as operative as they are in the lives of others. "When you are dependent on people most of the time [in the home environment] and you are alone in situations where nobody else can witness what is going on, you're pretty vulnerable," said a respondent. Another remarked, "At least in institutions you know that other people are [also] being abused."

A respondent, commenting on the social situation of people with disabilities, said, "We're alone a lot."[21] Some pointed out that the loneliness accompanying social isolation can be a factor behind victimization because people hungry for affection and a sense of belonging are more susceptible than others to various

forms of emotional exploitation. "They [people with disabilities] are lonely, need sex, need friends," observed one interview respondent. Concerning residents in institutions, another respondent noted, "There are a lot of emotional and psychological needs that get sexualized when there is no outlet for these feelings. They [institutional residents] will sometimes force sexual behaviour on people more handicapped than themselves."

Several respondents indicated that social isolation is a particular problem for people living in rural areas. It may be that people who are socially isolated in rural areas are more likely than others to *feel* their isolation and vulnerability. However, statistical data do not confirm the idea that rural persons with disabilities are actually more socially isolated than others. Instead, the data suggest that, as the population density increases, there is a tendency for people with disabilities to have less physical contact with family and friends, although the level of contact by means of telephone tends to increase. It appears that individuals living in small- to middle-sized cities are the most likely to have no identifiable contact with family or friends.[22]

Not all interview respondents saw social isolation in the form of segregated service environments as contributing to violence (e.g., group or special care homes, institutions). Many, however, did consider the social isolation that often comes with living in such environments to be a factor behind victimization. For a further discussion of social isolation as a form of abuse, see Chapter 3.

Lack of Financial and Other Support for Care-givers

Family members often find themselves functioning, by default, as principal care providers for persons with disabilities. For example, 82.7 per cent of adults who require assistance with

intimate personal care live with nuclear or extended family members. Of these persons, 71.8 per cent receive assistance exclusively from family members (e.g., spouse, parent, child or relative); neither friends, neighbours nor community agencies play a role in providing such assistance to these persons.

Respondents saw frustration and burn out of inadequately supported family care-givers as a factor contributing to the victimization of people with disabilities. "Unfortunately, the way human beings are, when they are experiencing stress themselves there's a tendency to pass it on to someone else. And, it's human nature to pass it on to the person who is more vulnerable," a respondent pointed out.

Lack of adequate support for care-givers was depicted not only as a problem for families, but for paid care-givers as well. Problems that were presented as contributing to a climate of violence in the relationship between the paid provider and the receiver of care include inadequate training, low wages, lack of breaks, lack of job rotation, negative organizational culture in service providing agencies and personality conflicts between providers and receivers of care that are not adequately addressed by management.[23]

In families, financial difficulties can exacerbate negative attitudes and stresses that arise from the lack of care-giver support. For 25 per cent of individuals living in nuclear or extended families who require more assistance from others than is available for daily activities (212,900 persons), their total family income from all sources is less than $15,000 per year. This compares poorly with non-disabled adult members of families, where only 10.8 per cent are in families with such low incomes. Only 22.4 per cent of these 212,990 persons receive disability pensions or benefits as a means of supplementing their family income, yet 42.7 per cent face expenses relating to their disabilities that are not reimbursed by any private or public disability pension or benefit plan.

In the same way, families having children with disabilities are more likely than other families to have incomes in the lowest quintile (Statistics Canada, undated). The more severely disabled the child and the greater the need for additional assistance in care-giving, the more likely it is that the family income will be low. The greater the number of family members who have disabilities, the greater the likelihood that family members will face financial difficulties.[24]

Families in which a member has a disability tend to be single income families. Women are more likely to be outside the labour force and to be playing a more active role as an unpaid care-giver when there is a family member with a disability. This increases the financial stresses on the families.[25]

In addition, the career options of both male and female earners can be limited as a result of increased care-giving demands in families where members have disabilities. Having to remain in a situation where some support services are available can mean forfeiting career opportunities: disability-related supports for the family member are not available or affordable in all parts of the country. Interviewers heard of family members who berated and blamed respondents with disabilities because of the impact that disability and care-giving had on their earning and career prospects. Family members who provide care to members with disabilities also tend to be more socially isolated than others, which is an established factor associated with care-giver violence irrespective of disability.[26]

All the above factors can aggravate care-giver stress and the climate of frustration, anger and other negative emotional states that contribute to family violence against individuals with disabilities.

Inappropriate Support

Human resource and contract issues

In some situations where interview respondents viewed care-

givers' denial of assistance with personal care as abusive or violent, scheduling procedures and resource constraints in the human services sector were singled out as a contributing cause. The demand for attendant and other services outpaces the number of funded care providers. As a result, the basic needs of many people with disabilities are not met because providers are either unavailable or under time pressure to serve individuals quickly and move on to the next client. Sometimes, however, sheer irresponsibility on the part of attendants and other care-givers was cited as the root cause of the abuse. Some care-givers simply do not show up for work, which leaves people with disabilities lacking the supports that may be critical to their well-being.

It was also suggested that the denial of essential support can result from how unionized workers interpret Health and Safety regulations in conflicts with management. An example was given of a 250-pound unionized attendant refusing to lift a 90-pound client because of concern about potential back injury. Depending on the client's weight and the nature of relations between labour and management at service providing agencies, people with disabilities may find themselves as pawns in labour-management conflicts. "A non-verbal disabled consumer has no hope whatsoever against big labour," said a respondent. Relations between unionized workers, management and consumers with disabilities is a complex issue beyond the scope of this research.

Lack of care-giver screening

Several interview respondents remarked that criminal checks are sometimes conducted on job applicants for attendant, homemaker and other service providing agencies. However, it was pointed out that this process is not universal. As a result, persons who have been charged and convicted of sexual and

other offences against persons are working in the human services field.

It was also pointed out that criminal record checks often turn out to be "useless". Many cases of alleged victimization against people with disabilities do not come before the courts because no charges are laid or because charges are dropped. Consequently, there are no recorded criminal convictions that the employer can use to judge a job applicant's suitability for employment in the human services sector.

Employers in the human services are not universally performing even the simplest of security checks, such as obtaining job references from previous employers. Therefore, perpetrators continue to move about within the system.

Overprotection and limited education and life experiences

Several respondents referred to the overprotectiveness of some care-givers as a factor that contributes to victimization. For example, family socialization may deny individuals opportunities to develop and exercise their independence and personal control over their own lives. It was pointed out that this can have serious consequences. A respondent said, "Families think for them. They are brought up [so] that other people will think for them. So if somebody comes along and says 'Come for a drive with me,' they just say to themselves, 'Somebody told me to come for a drive, so I'll go.'"

The research identified other agents who play a role in socializing people with disabilities into passivity and compliance. For example, as a result of living in segregated residential settings for years on end, individuals with intellectual disabilities in particular "haven't received information about their rights and about abuse and what they can do about it. ... People think they can't understand — they [care-givers] overprotect them. But they can understand a lot." Another

respondent expressed the same idea: "If others have to make decisions for you or care for you, you lack social skills and judgement in regard to people." This lack of acquired judgement can leave individuals vulnerable to exploitation and other harms.[27]

These concerns were not limited to institutionalized persons with intellectual disabilities. Speaking more specifically about women with disabilities who have been sexually assaulted, a counsellor who took part in the research remarked, "We don't educate them. We overprotect them."

For some individuals, limited education and life experience result from the general barriers that people with disabilities encounter while attempting to participate in society. This lack of socialization can leave people unaware of important issues, such as sexuality and abuse. Individuals may be entirely unaware of their rights or about what to do in the event of harm. Or they may simply be too trusting of individuals with malevolent intent. In general, limited education and life experience were seen as leaving individuals with a restricted capacity to recognize and deal effectively with dangerous situations.[28]

Other individuals have been raised in physically or psychologically abusive family and extra-familial care situations and in the process have been kept socially isolated. As a result of their narrow socialization, they have come to consider the climate of violence in their lives as normal. For some, it is not until they have an opportunity to encounter non-violent family situations that they are able to recognize the violence and reject it. One respondent who had carried the effects of this kind of socialization into adult life explained, "I was afraid to get out of the abusive relationship. Because ... parents ... the [psychiatric staff], etcetera, had put me down ... I was vulnerable to being put down in a love relationship —

which continues to put me down ... I could not recognize I was being put down, because that had been the norm for me."

Lack of Control and Choice

Numerous interview respondents indicated that the lack of control experienced by persons with disabilities can contribute to their victimization. Some respondents characterized lack of control as a physiological issue — limited ability of the individual to govern their bodily movements. This limited control over bodily movement can result from the disability itself (e.g., a mobility impairment) or from the environment (e.g., lack of architectural modifications to the family home that would provide escape for a survivor who is a wheelchair user). In either case, these individuals are vulnerable because they are not at full physical liberty to escape dangerous situations.

Other respondents described a lack of control in power relations. For instance, one felt that people with disabilities are more vulnerable than others to violence in "any situation where there are people in a position of power over them — sheltered workshops, learning institutions ... where people need more personal care". Not having control in such situations means being "in a position that allows other people to take advantage of them". During the research, many stories were told in which individuals' personal control over their own affairs was thwarted by others who subsequently took advantage of the situation.

Lack of control was closely associated with lack of choice over who provides supports and how. Although not all respondents saw this as an issue, others saw it as a pervasive problem. One respondent commented, "People have little control over who provides care, whether they are living in a nursing home or with family members. This makes them

vulnerable." Lack of control over who will provide support can have dangerous consequences. For example, one interview respondent indicated how she had no control over which attendant care provider showed up at her door. The attendant care agency made that decision. Typically, males who she had never seen before would appear. Eventually, one of these individuals assaulted her, a man who had a previous criminal record for sexual assault.

When asked during the HALS survey in 1991, "How much control do you feel you have in making decisions that affect your everyday activities?", 70,585 Canadian adults with disabilities living in ordinary households indicated "none". A further 171,225 indicated "not very much".[29] This question was not put to adults residing in institutions. However, many interview respondents expressed particular concern about the lack of control people with disabilities experience in health and mental health facilities, a problem that has been identified by other researchers.[30] With regard to individuals in long-term or permanent medical and professional care, one respondent felt that professionals are presumed to have the right of access to the bodies of patients and are expected to exercise control over them. It was precisely this loss of patient control that was cited as a factor contributing to violence and abuse. Another respondent reported that she had been admitted to a psychiatric facility and had been perceived by a physician as "out of it". This condition "gave the doctor the feeling he could get away with fondling me". A male respondent expressed the same concern: "Take me to a hospital and I'll be scared to death. Leave me at home and I'll be my own master."

In their reports of situations, many respondents presented violence against people with disabilities as a deliberate abuse of power and control by individual perpetrators. In the words

of one respondent, "It's a power thing. ... They [people with disabilities] are the most vulnerable so they are perceived as the safest people to abuse." This view was echoed by another respondent: "Anyone with an urge to act out in a sexually deviant way is going to pick the person who is the most vulnerable, the person who is least likely to tell, the person you can manipulate to do what you want."

Control by others was also presented as the result of systemic factors, such as resource constraints, which do not always involve malicious intent on the part of care-givers. "Very often decisions are made ... as an act of convenience," a respondent explained. "For example, in an institution where you are short staffed, it's easier to hand someone their clothes and say, 'Here, wear these,' than to let them take time to decide. Giving people choices like that instills in them the idea that 'I'm a person and I have the right to make choices.'" By implication, inadequate resource allocations can deny persons with disabilities the opportunities to make ordinary decisions, which erodes their sense of self, of having rights and of having control over events in their lives. This can leave individuals susceptible to exploitation and other harms by persons whose intentions are self-serving or malicious. Other researchers have identified the need for funding for service delivery and monitoring as a key to detecting and preventing violence in institutional settings (Glick et al., 1983).

Giving up personal control was identified in some cases as "a way of coping with the intrusiveness of personal, intimate care and handling". One particular respondent felt that some individuals in effect relinquish control over their situation "by distancing themselves from their bodies" and that this distancing increases the likelihood of being victimized.

Whereas lack of control and choice may be factors that contribute to victimization in a particular situation, lack of control is sometimes pervasive in many aspects of a person's life. For

example, one respondent indicated that she had neither the education, the financial resources, the social status nor the physical ability to take effective control of her life. As a result, she did not see removing herself from her an abusive situation as a viable choice.

Compounding the vulnerability of people with disabilities are the particular difficulties they may encounter while attempting to defend themselves from their perpetrators. As one interview respondent put it, "People seem to pick on someone they think can't defend themselves." One respondent stated categorically, "They can't defend themselves." Another indicated that "if you're going to take it out on somebody, you're not going to do it to someone bigger, smarter, etcetera." Of course, it is simplistic to assert that no person with a disability has the capacity for self-defence. However, there was a general sense during the interviews that people with disabilities are more vulnerable than others in this regard. The limited ability of individuals with disabilities to resist their perpetrators may stem from relative physical weakness or disability-related physical limitations, such as a mobility impairment.

Other Factors

Perpetrator Abuse of Alcohol and Drugs

Several interview respondents indicated that alcohol and drug abuse by perpetrators were factors that contributed to the victimization of a vulnerable person. Alcohol abuse in particular has been established by other researchers as a factor associated with violence.[31] Whether these substances contribute disproportionately to the victimization of people with disabilities cannot be settled without further research into the issue.

Limited Communication

The limited communication abilities of some persons with disabilities can render them particularly vulnerable. One respondent felt that individuals are susceptible to victimization "cause they can't speak up for themselves ... cause they're nervous". Many respondents remarked that violence and abuse occur precisely because perpetrators feel their victims will not be able to tell others about such incidents.[32]

"Inappropriate verbal skills" was cited as a problem that may lead to individuals with learning disabilities in particular "being misunderstood for their actions". In some situations, the individual's social cues may be misread by persons who do not necessarily have an intention to exploit or to create harm but whose actions ultimately have those effects. This could occur, for example, when an individual makes a display of affection that is misread and results in unwelcome sexual advances.

Given the multiple ways in which people with disabilities are vulnerable to violence and abuse, common sense suggests that safeguards to prevent, identify and address victimization are critical to their well-being. Subsequent chapters of this report focus on safeguards and other response mechanisms. It is important to point out, however, that such safeguards — laws, policies, protocols or other response mechanisms — were generally not viewed by interview respondents as widely operative or effective. Some respondents who had been victimized indicated that little happened in response and nothing happened to reduce the likelihood that the incidents would reoccur. One individual, commenting on policy and reporting arrangements in the health care setting in which he had been abused, indicated flatly, "There is no use reporting this kind of thing. You cannot report to the people you are complaining about." The lack of effective safeguards can aggravate other factors that increase the chances of victimization.

Notes

1. For more discussion on responses, see Chapter 5.

2. For more discussion on legal issues and the criminal justice system, see Chapters 6 and 7.

3. For discussion of cultural representations and stereotyping of persons with disabilities, see also Health and Welfare Canada, 1993b; Szasz, 1993; Foster, 1989; Fine and Asch, 1988a; Guitner and Joe, 1988.

4. See Statistics Canada, Centre for Justice Statistics, 1994b, Table 2.

5. Using data sources such as the General Social Survey microdata on victimization, it should be possible to determine more precisely the links between gender and the extent and the types of violence that persons with disabilities encounter. However, such data are unlikely to shed much light on disability-related factors that are associated with victimization, such as reliance on social service providers for intimate personal care. In addition, the sample size for the survey is relatively small. This could affect the reliability of multiple cross-tabulations of data pertaining to issues associated with violence against the even smaller sub-samples of males and females with disabilities.

6. For example, due to their disabilities, 69.1 per cent of females rely on others for assistance with one or more daily living activities. Among males this is true for 51.4 per cent. Nearly one-half of females with disabilities (47.9 per cent) need more assistance from others than is available, where this is true for only about one-third of their male counterparts (33.6 per cent). Although the

proportions of males and females receiving assistance for intimate personal care are roughly equivalent, females are much more likely (32.4 per cent) than males (23.4 per cent) to be receiving assistance from someone other than family, friends or neighbours, such as home care workers, attendant care providers or privately employed help. Females are more likely to be poor (24.7 per cent of females with disabilities have no annual income from any source in contrast to only 2.2 per cent of their male counterparts). Females with disabilities are roughly one-third more likely to be living in low income situations than males (29.5 per cent as compared with 20.9 per cent). Females with disabilities are also much more likely to be completely housebound because of their condition (9.5 per cent as compared with 5.9 per cent among males).

7. HALS 1986 does not provide a race variable and so cross-tabulations on the basis of race are not possible.

8. A variable was derived to capture individuals who speak neither English nor French *and* whose ethnicity is neither British nor French. Strictly speaking, this is not equivalent to a race variable because the derivation would include persons of colour who speak neither English nor French and Caucasian persons who speak neither of the official languages and whose ethnic background is neither British nor French (e.g., Eastern Europeans who speak only their native languages). In addition, the variable excludes persons of colour who speak one or both of the official languages.

9. Some 81 per cent of selected persons from the minority groups have total personal annual incomes from all sources of less than $10,000, compared with 56.8 per cent among other persons with disabilities.

10. A higher proportion of selected individuals who have these needs have either none or not enough of the intimate personal support that they require: 58.8 per cent compared with 54.7 per cent among other persons with such needs.

11. Only 17.5 per cent of these women receive help from someone other than family, friends and neighbours, such as home care, attendant care or privately employed help. In contrast, 46.7 per cent of other women with disabilities receive support services from community providers.

12. 4.2 per cent compared with 3.4 per cent.

13. 4 per cent compared with 2.4 per cent. Moreover, 18.4 per cent of the selected women with disabilities live alone compared with 14.9 per cent among all selected persons from ethnocultural minority groups (male and female).

14. Among these persons, 7.7 per cent indicate that they are only partially or not at all able to make themselves understood by persons other than immediate family and friends.Only 3.7 per cent of other adults with disabilities indicate that they have this problem.

15. A few interview respondents cautioned about feeding into the stereotype that people with disabilities who are victimized are, as a group, poor. However, the overwhelming majority of interviewees with disabilities who had been victimized had very low incomes.

16. See Statistical Appendix, Table A1.

17. Of people with disabilities who receive welfare, 40.8 per cent indicate that they "would like to do more" in the way of social and leisure activity outside of their own homes. For non-recipients, only 32.7 per cent indicated the same.

18. Fully 24.8 per cent of wives or female common-law partners with disabilities have no personal income from any source and are therefore economically dependent on the income of husbands, partners and other family members.

19. See Chapter 3. According to HALS, 1986, 5.5 per cent of persons with disabilities whose total personal income from all sources is less than $10,000 are hospitalized three or more times in a given year. This compares with only 1.6 per cent among individuals with disabilities who have annual incomes of $35,000 or more.

20. See also Sobsey, 1994 and 1988b.

21. Indeed, the 1986 HALS survey shows that people with disabilities are much more likely than their adult counterparts without disabilities to be living alone — 18.7 per cent compared with 8.5 per cent. Fully 354,540 adults with disabilities, or 12.7 per cent of all adults with disabilities in Canada, never leave their homes to visit friends or family in a given month. Over one-quarter of these people (96,400 persons) are particularly isolated in that they never engage in social activities in a given week, even in their own homes with family or friends and never converse with others by telephone. Some 23,370 seem completely cut off from the world beyond their own walls in that they never visit others inside or outside their own homes, never converse by

telephone and are completely housebound due to their physical condition.

22. See Statistical Appendix, Tables A1-A4. Concerning the general population, the Canadian Centre for Justice Statistics has found that criminal victimization is less likely to occur in rural settings than in urban ones. See Statistics Canada, Centre for Justice Statistics, 1994b, Table 2.

23. See also Gnaedinger, 1989; Wachtel, 1989; Fulmer, 1988; and Groce, 1988.

24. In families where no members have disabilities, only 10.7 per cent are living below Statistics Canada's "low income cut-off". Where one family member has a disability, 16 per cent live below the cut-off; where two or more family members have disabilities 21.2 per cent live below.

25. For example, in families where working-age female spouses or common-law partners do not have disabilities and where there are no other family members with disabilities, 60.1 per cent of those females are employed. However, where non-disabled female spouses or partners are in families with one member who has a disability, only 50.2 per cent are employed. This number drops to 40.3 per cent where two or more family members have disabilities.

26. Garbarino, Brookhouser and Authier 1987, p. 5. See also pp. 24-36 concerning the importance of social support for families in preventing family violence against young persons with disabilities in particular.

27. Peterson and Bossio (1989) have examined how institutional residents learn compliance and are discouraged from exercising self-determination as a result of strict institutional regulations and pressures upon residents to conform to routines and rules.

28. Statistical data suggest that familiarity with where to get information concerning human rights increases with level of education. Generally speaking, males are more knowledgeable on this matter than females. The most knowledgeable are females with university degrees. The least knowledgeable and by far the largest group are females with disabilities and only primary education. See Statistical Appendix, Table A5.

29. This information was provided by a representative of Statistics Canada and is based on the raw 1991 HALS data.

30. See also Stimpson and Best, 1991; Peterson and Bossio, 1989; Burstow and Weitz, 1988; Fine and Asch, 1988b.

31. See Statistics Canada, Centre for Justice Statistics, 1994a.

32. According to HALS, 1986, 126,680 adults with disabilities are only partially or not at all able to make themselves understood by people other than immediate family or friends; 71.1 per cent of these persons have intellectual, learning or psychiatric disabilities in addition to their speech difficulties and only 34.7 per cent know where to get information on their human rights; 27.6 per cent of those 126,680 persons have a hearing impairment and neither lip read nor use sign language.

Chapter 3. Faces of Violence and Abuse against Persons with Disabilities

When persons with disabilities are in harm's way, the results can be devastating. This chapter provides an overview of actions and circumstances that interview respondents perceived as violent and abusive towards people with disabilities.

Violence and abuse against people with disabilities include acts that are widely considered by the public and in law and social policy as acts that *all* members of society should be safeguarded against by means of deterrents and punishments. These include a range of criminal offences proscribed under Canada's *Criminal Code*. Sexual and physical assaults against persons with disabilities in particular have received some attention from the research community. However, there are many other acts and situations to which persons with disabilities are particularly vulnerable but which are not widely understood to be violent or abusive. The following discussion describes some forms of violence identified during the research interviews.

Physical Acts as Violence

A range of discrete acts involving physical force or physical action were reported as violent in nature. Some of these acts are committed by care-givers who are in a position to take advantage of their relationships with people with disabilities. However, some acts do not involve care-givers as the offenders. Some violent and abusive acts are of a sexual nature; some are not.[1]

Care-giver Physical Violence

A range of physical assaults were reported as occurring in settings where care is provided to persons with disabilities. These include acts of care-giver violence in health care settings, in institutional settings where social services are provided (e.g., rehabilitation centres or in special care or group homes) and in private dwellings (e.g., the home of the abused person, where a para-professional may provide attendant care services or where the parent plays the role of care-giver).

Overt care-giver assault and abuse

Some acts by care-givers are impossible to construe as acts of care-giving. For example, interviewers heard about non-verbal clients of a group home who were fed by an "educator" so quickly that the individuals suffocated. It was reported that individuals living at another special care home had their faces pushed forcibly into their food by special care home operators when they refused to eat. A respondent related how a woman who wet her bedding was put out into the cold by her special care home operator who had wrapped the wet sheets around the woman's neck. Another individual — a survivor of abuse — spoke about how he was tied up with a dog chain, beaten with a belt and a spoon, punched in the face and choked by a special care home operator. Other incidents involved

individuals who were pinched and slapped by care-givers or were forced to eat meals on the floor or on the toilet while in special care homes.[2]

These physical acts occurred in situations where formal care was provided. Situations were also reported where young persons with disabilities were physically harmed by parents and where women were battered by husbands and boyfriends. In these instances, family members were providing informal care and support for disability-related needs.

Physical violence as a perversion of care

Some acts of care-giver violence are more subtle than overt assaults in that they take the outward form of care or treatment. Several respondents with mobility impairments indicated that rough physical handling by various health care professionals was fairly common. In several instances this roughness was portrayed as the result of insensitivity rather than malice on the part of ambulance personnel and hospital staff. Nonetheless, such acts were clearly unwanted, had the potential to result in personal injury and were seen as violent or abusive by the individuals affected.

For example, an action experienced as violent was when a health care professional "yanked" a pillow from under the respondent's head. The context of the event helps to define its character as violent. The individual had health complications that involved a restricted breathing passage. The health care professional's removal of the pillow meant that the respondent's head fell into a position that cut off the respondent's air supply. Fortunately, the individual survived the incident. In this story, the health care professional's action may seem like a relatively trivial lapse of good judgement and could even be construed by the superficial observer as an act of attentiveness to the individual's comfort. However, the act caused considerable physical and emotional discomfort to the person, who had little

control over the care-giver's action and clearly would not have consented to it. The person affected perceived that the care-giver understood full well the discomfort that was being caused and seemed to intend it. The incident also had the potential to be life-threatening.

"Pushing and pulling into uncomfortable positions on a chair" by a health care professional was cited by another individual with mobility impairments as a particular form of rough handling that was perceived as violent. Again, to the casual observer, isolated acts of this kind could be construed as well-intentioned though unsuccessful attempts by the professional to ensure patient well-being. However, the respondent indicated that these acts took place in the context of other acts that the respondent perceived as degrading and causing emotional and physical suffering and intimidation. The respondent perceived the isolated acts of "pushing and pulling" as manifestations of a general and spiteful intent by the care-giver to intimidate and degrade the patient.

Several respondents with psychiatric difficulties spoke about physician- and psychiatrist-prescribed over-medication or medication with inappropriate drugs as violent and abusive. Medications rendered one respondent so unable to concentrate and read that, in the respondent's words, "you don't know your rights". In another reported incident, the administration of medications and the resulting impact on the patient's awareness set the stage for the therapist to sexually abuse his female patient. In yet another situation, a young male respondent with a disability was subjected to experimental drug treatment to which he had not consented and which produced painful side effects he had not been advised about. In all these situations, the unwanted administration of medications were by individuals in positions of trust and authority.[3]

Physical restraint in psychiatric care facilities was cited as another form of violence that has the outward appearance of care or treatment. In these situations, the subjects are overwhelmed by the physical force of others who have authority and physical power on their side. Injection of medications without the subject's consent accompanied several incidents. Interview respondents saw the non-consensual administration of medications as adding to the violent atmosphere. One respondent sustained a permanent physical injury as a result of restraint. Some degree of psychological fear, trauma and anguish also results from such events.

The line between care and violence was blurred in an incident related by one interviewee who was hospitalized due to a condition resulting from his disability. The patient relayed to health care professionals how his particular disability created physiological anomalies that had to be taken into account during diagnosis and treatment. The physician simply ignored the patient and referred the matter to a junior rather than to the specialist physician whom the patient had requested. An inappropriate treatment was administered that resulted in prolonged internal bleeding.

It is not uncommon for individuals who have been sexually assaulted to experience re-victimization after the fact, under the guise of care. This is illustrated by one case where a forensic medical examination was performed on a female with a disability who had been sexually assaulted. The interview respondent indicated that the roughness with which the physician conducted the examination was more physically and emotionally traumatic than the actual sexual assault.

Health care providers were by no means the only care-givers singled out during the interviews as perpetrating violence in the form of care. One respondent identified experiences of

"unnecessary roughness" by attendant care providers as a form of violence. In this case, the roughness occurred while the attendant moved the client with mobility impairments from one position or place to another. Bathing clients in water that is either scalding hot or too cold was cited as a further example of malevolent violence and abuse by attendant care providers.

Attendant care providers and family members who intentionally "leave people on toilets longer than necessary" were also depicted as perpetrating violence. In these situations the act of care-giving is meant to assist the individual with a mobility impairment to eliminate bodily wastes. However, deliberately leaving individuals longer than necessary on the toilet is an action over which the receivers of care have little control. The action may not result in physical harm, yet it causes emotional degradation and unnecessarily restricts the individual's liberty.

The forceful control of clients by care providers in large residential care facilities was perceived as another form of violence. For example, care-givers force clients to do things and go places that meet institutional priorities and follow routines, regardless of the clients' wishes.

Aversive treatment by care-givers was also characterized as abusive by respondents. Aversive treatment is most typically directed to individuals with intellectual and psychiatric disabilities. It involves care-givers performing deliberate interventions that are designed to create discomfort for the person being treated, in an effort to modify the person's behaviour. These actions can include verbal reprimands, forcing individuals to do actions they do not want to do, slapping and pinching, various forms of physical restraint, spraying water in their faces and spraying lemon juice in their mouths. Perhaps the most extreme form of intervention along the continuum of

aversive behaviour management techniques is "faradic stimulation"[4] — the administration of an electric shock following an unwanted behaviour. Specially modified electrical devices, including helmets and body suits implanted with electrodes, are used in this form of aversive treatment.[5]

Sexual Assault and Sexual Abuse

Reports of sexual assaults and sexual abuses were commonly given during the research interviews. In some cases, vicious physical force accompanied such acts. In many reported instances the survivors were females; however, male sexual abuse and sexual assault survivors also told their stories to interviewers.[6] Some of these incidents were one time occurrences. However, others were ongoing. For example, a woman reported being sexually assaulted for two years, once a week, by her care-giver when his wife went out. The incidents began when she was 12 years old and continued until she was 14 years old.

Some of the sexual assault and abuse was reported to have occurred in situations where disability-related care or service was provided. One respondent discussed an incident where a female acquaintance had been sexually assaulted in a group home. Another male respondent spoke about being sexually assaulted by a male attendant. Another spoke about sexual abuse and assault perpetrated by a taxi driver. Another reported sexual abuse perpetrated by "many therapists and psychiatrists" against numerous people with disabilities, including herself.

In other instances, the sexual offenders were identified as family members. Typically, although not exclusively, the offenders were males, including grandfathers and foster-, step- and natural fathers and uncles. Male friends of family members were identified as perpetrators,[7] as were mothers and sisters. Students — on school grounds and on school buses — were also pointed to as perpetrators of sexual offences.

Other Physical Violence

Many other forms of violence involving physical force or physical action against persons with disabilities were reported. These acts take the extreme form of murder and alleged murder. Other forms include the beating, manhandling and bruising of psychiatric patients by police and ambulance personnel. One individual said he had been mistaken for drunk by a police officer and had been pinned to his car seat for interrogation. This individual's gait is affected by his disability. As a result, he reported, "The police always think I'm drunk when they see me walking funny."

Another respondent with an intellectual disability related the details of an incident in which she was struck by the superintendent of her apartment building after she rejected his sexual overtures. A number of other female respondents told about being physically assaulted by husbands or boyfriends. Interviewers also heard about the physical abuse of respondents with disabilities as children in foster care and natural families.

Some survivors with disabilities and social service providers attributed the survivors' psychiatric disabilities in large part to abusive family circumstances. For example, one respondent told how when she [the respondent] was a child her mother had burned, whipped and beaten her with various instruments and committed a number of other physically violent acts against her. The mother construed such actions as appropriate ways to deal with her supposedly "feeble-minded" daughter. Not surprisingly, the daughter is experiencing ongoing psychiatric difficulties.

Frightening physical actions that stop short of causing serious physical harm were also cited as forms of violence. These include: when a stranger comes up from behind and grabs a person who is visually impaired; when someone jumps in front of, or attempts to trip, a person with a visual impairment; and when a care-giver abruptly moves an individual with a

mobility impairment without warning and with the intention of startling him or her. Forcing persons with physical disabilities or health problems into activities, such as moving from one position to another or getting out of bed, when they are exhausted or in pain was cited as yet another form of abuse.

The research also identified physical violence between recipients of care in care settings (e.g., between institutional residents). Here, the acts involve physical harm, emotional trauma and a lack of consent. The two people may be similar in strength and size and may coexist as relative equals in the care setting before the incident occurs. However, during the incident the perpetrator dominates the victim. For example, a resident may physically assault another resident. This may be a one-time occurrence or part of an ongoing pattern of abuse.

Denial of Rights, Necessities, Privileges and Opportunities

All physical acts of violence involve an invasion and disruption of the bodily or psychological well-being of the person under attack. The person affected does not consent to the acts and is treated as an object or an inferior, not as an equal. Frequently, the abuser is in a position of power, trust or authority. However, interview respondents reported a range of deliberate denials that may not involve physical force or action, but which are nonetheless experienced as violent or abusive.

A distinction is drawn in the following discussion between neglect and deliberate denial. Neglect can result from thoughtlessness, "an act of omission, through ignorance or oversight" (Dubowitz and Egan, 1988). The denials that respondents personally experienced as violent were generally intentional.[8] Some perpetrators explicitly intended discomfort or harm and used denial as the means to achieve that objective.

In other situations, neither harm nor discomfort were deliberately intended. Indeed, some perceived good, such as protecting the individual or safeguarding their personal affairs, may have been the motivation. However, a deliberate act of denial was required to actualize the intent and the act had the effect of compromising the individual's physical or psychological well-being.[9]

Denial of Family

A number of female respondents with psychiatric disabilities indicated that they had their children apprehended by agents of the state, most typically social workers. Here, the respondents had been deemed "unfit" as parents because of their disabilities. The thwarting of the intent to have a family was perceived as another form of violence, again one typically directed against females with disabilities. Two examples reported were the intervention of health care professionals in women's decisions concerning child-bearing and pressure by social workers for women to undergo medical procedures such as tubal ligations.

Such denials of family life were perceived by respondents to be wrongful and callous system interventions based upon prejudice and stereotypes about disability. Interviewees portrayed social workers who apprehend children as having virtually unlimited, capricious discretion and power to remove children from their families. A respondent said, "I feel powerless. If I [have an emotional] break down she [the social worker] will take my kids. It hurts. I have to keep the house clean in case the social worker invades my house."[10] Parents — most often women with disabilities — have little status with the welfare and social service system and therefore have little say in, or control over, the matter. The actions resulted in enormous and ongoing personal anguish. One respondent said, "I know someone who committed suicide because she couldn't have a try to bring up her son."

Denial of Economic Security

Other respondents experienced the systematic denial of economic security and control in their lives as violent or abusive.[11] This problem takes several forms. For example, one respondent related an incident concerning the psychiatrist of a woman with a psychiatric disability. Worried that the woman's husband was spending the benefit money, the psychiatrist persuaded the welfare authorities to terminate the woman's disability benefit cheques. The fact that the woman was thrown into economic crisis as a result of the psychiatrist's and welfare case-worker's interventions did not seem to be an important consideration.

Another respondent viewed her ex-husband's refusal to provide child support as a continuation of a broader pattern of spousal abuse. The husband's denial of economic resources seriously aggravated the woman's already precarious and stressful economic situation.

One respondent described her husband's absolute control over all aspects of the family's finances as abusive. This control rendered her entirely dependent on his goodwill and preparedness to support her. Unfortunately, there was little evidence that her spouse cared for her well-being. Similarly, a male respondent perceived his wife's control over the family finances as abusive. A respondent with an intellectual disability also felt that "keeping money away from a person" was a form of care-giver violence that includes situations where paid or unpaid care-givers exercise control over the personal finances of persons with disabilities.

A man who had become disabled in an accident, rendering him completely unable to work, related how members of his immediate family (including his wife) and circle of

acquaintances refused to allow him to sell properties he jointly owned with his wife. The respondent saw this as financial abuse because the interference resulted in a significant personal financial loss and a lack of freedom to manage his own affairs.

Several respondents spoke about outright theft by acquaintances and care-givers as a form of economic violence. For example, a respondent with a visual impairment described being short-changed by taxi drivers "because they think we can't see what they're giving us". Others told of being deliberately and frequently short-changed by cashiers.

The incidents of economic violence reported during the research included: "poor pay for work"; being refused employment, promotions and responsibilities at work because of disability; and being fired on account of disability. Since poverty is commonly experienced by people with disabilities, respondents who experienced financial abuses generally considered it significant to lose economic opportunities and resources. In many instances, the individuals relied on the goodwill of others who were in positions to provide, withhold or take money.

Denial of Conditions Necessary for Physical and Emotional Well-Being

Some respondents cited as violent the denial of conditions that are usually considered basic requirements for physical and emotional well-being. For example, one respondent used the term "abusive" to describe the housing that people with disabilities are given by the welfare system, noting that "if a child lived in those surroundings, that child would be apprehended". Several other respondents used the same kind of language to describe the living arrangements of many people with disabilities.

Other respondents pointed to the denial of food and fluids by care-givers as an act of violence. In one reported instance, care-givers had denied food as a means of keeping the respondent's weight low so as to facilitate moving the individual. In another situation, care-givers regularly denied fluids as a strategy for limiting the number of times they would have to assist the respondent to use the toilet. Similarly, care-givers refusing to give clothing to a psychiatric patient who "didn't behave" was characterized as abusive. Here, the denial reflected an intent both to discipline the respondent and to uphold institutional routines and dress codes.

Denying a person with a mobility impairment the assistance required to get out of bed, to wash or to dress was also portrayed as a form of abuse. Care providers who leave clients in bed for prolonged periods of time were singled out as engaging in an abusive form of punishment. Care-givers who leave individuals to lie in their own urine or excrement were presented as perpetrating an extreme denial of ordinary care.

The routine denial, in a psychiatric setting, of counselling to help psychiatric patients deal with feelings of aggression was seen by a respondent as paternalistic "neglect", and experienced as a form of violence against the patient. A physician denying prescription medications to an individual with psychiatric problems, which a respondent indicated was a factor in a woman's subsequent suicide, was portrayed as an act of physician violence.

Denial of Social Interaction and Inclusion

Several interviewees pointed to the obstruction of social interaction with others and hindering social integration as violent and abusive. One female respondent with a mobility impairment cited her husband's refusal to take her out of the

family residence. The husband denied her the opportunity to socialize and to experience a sense of membership in the wider community, which took place in the context of a broader pattern of spousal actions that she considered oppressive, degrading and abusive. Similarly, a care-giver socially isolated a group of non-verbal clients in a small room of a group home. This was reported as an act of violence and abuse.

Another means of socially isolating individuals is taking away a piece of technology upon which a person depends for social interaction, such as a Telephone Device for the Deaf (TDD). In one reported incident, the care-giver — a husband — went as far as blocking all social interaction between his deaf wife and her friends and family members.

Pre-empting social communication with people who have limited ability to verbalize was portrayed by several respondents as violent and abusive. This can take several forms, from "not taking the time to allow them to express themselves" to "unplugging the call bell if the care-giver can't understand what the person is asking for". Here, the express or implied wish of the individuals affected is to make themselves understood, but they are more dependent than persons with ordinary communication abilities on the willingness of others to participate in the communication. Unwillingness to communicate or disinterest in communicating with the individual who has limited verbal skills can leave that person with no voice or status in relation to those who are in a position to prevent or ameliorate harm. This leaves the person with little power or control to alter the situation of risk. When individuals frequently find themselves in this situation, it is reasonable to infer that they routinely experience humiliation, frustration and even fear.

Pre-empting communication with people with disabilities who do not have difficulty with speech or hearing was also presented as a form of violence. The example cited was of the care-giver who refused to participate in a dialogue with the care-receiver because it "isn't in the union contract". Here, the care-giver effectively denied the person an opportunity to feel as if he were a member of society. This seems to be a particular problem where individuals have little personal contact with community members aside from their care-givers.

One young respondent said "being told in gym class that 'you make us lose so we don't want you on our team'" was an act of social exclusion that she considered harmful. Non-disabled persons might consider such peer rejection to be an inevitable part of growing up. However, she saw exclusion from the team as consistent with a broader cultural context of violence, abuse, disrespect and rejection of persons with disabilities. These incidents happened "all the time. It's part of your life. Name calling. Being short changed. Sexual assault. Patronizing. Assuming I'm low functioning."

Another exclusionary incident was related in which a teacher informed a young person who had sustained a brain injury and who was having difficulty at school: "You are not the type of student we want around here — get back to where you belong." The teacher was indicating that the student really belonged in the special school for students with disabilities where he previously had been. The young man was overwrought at the teacher's remark and saw the teacher as representing the school system at large, which he believed judged him as a failure. Fulfilling the system's and the teacher's determination that he was an unwanted failure, this 15-year-old ran away from home and lived on the streets with no resources and little experience, in a large city where it was feared that he could be further victimized because he was not "street smart".

Similarly, a respondent with a learning disability who had difficulty with post-secondary school courses felt that being "kicked out of school because of disability" was an exclusionary act of violence. In this case, the instructors failed to make any accommodations for her disability, such as providing extensions for course work. Other than mentioning the frustration and humiliation that resulted from the action, the respondent did not explain further why she construed this as an act of violence. However, the exclusion from education almost certainly weakened her opportunities in the labour market and her earnings potential, which may be seen as violent because it contributes to the respondent's social disadvantage.

Other exclusionary behaviours, such as when non-disabled persons move away from people with disabilities in restaurants and in other public places, were depicted as emotionally violent.

Denial of Ordinary Freedoms

The denial of ordinary freedoms was identified by several interview respondents as another manifestation of violence. It takes a number of forms such as when a care-giver denies privileges and comforts such as cigarettes and coffee. It may be parental overprotection to the point that, as an adult, the person has no opportunities for independence. Parents and other care-givers may refuse to let an individual visit friends or take part in community activities that would help the person be more independent, such as using the bus or taking a night course. The denial of freedom may also take the form of "totalitarian" control by psychiatrists of their patients.

A key issue in such situations is the ongoing regime of control imposed upon individuals — a regime determining activities that individuals would prefer to control themselves and that most other citizens would ordinarily control themselves. In some circumstances, no particular denial is construed as violent. Instead, a relentless series of denials and controls are together perceived as oppressive and abusive.

Malicious Patterns of Communication as Indicators of a Violent or Abusive Intent

Interview respondents reported two patterns of interpersonal communication as expressions of violence: threats; and insults and harassment. These problems are intertwined and were typically experienced as verbal and emotional abuse.[12]

Threats

Threats against persons with disabilities take several forms. A respondent with a visual impairment indicated that threats from strangers such as, "Give me money or I'll hurt you", are experienced as acts of violence. Threats by husbands and boyfriends were reported by female respondents as forms of violence. Respondents also cited as violent and abusive the threats of perpetrators who warn victims with disabilities about the dire consequences of disclosing sexual and other abuses.

One respondent reported that attendant care providers threatened "to leave a person if they do not eliminate [bodily wastes] *now*". If the individual was unable to eliminate bodily wastes on command, he or she faced two choices. The individual could eliminate later, but perhaps without using the toilet, or retain the bodily wastes until the support service materializes again, which may take hours and even days. The former option is degrading and may provoke care-giver harassment. The latter could result in serious health problems such as a kidney infection if there is a long wait.

Stalking behaviour, a pattern of communication that is deliberately intended to generate fear and anxiety, was cited by several interview respondents as a form of violence. A respondent with a visual impairment said, "On the streets, people ... follow you. I can't tell if someone looks threatening."

A respondent who was discharged from a psychiatric facility reported that she was stalked for many years by one of the institution personnel upon her return to the community. Anonymous phone calls of a threatening nature were perceived in much the same way as stalking.

Other threats that were reported as violent and to which people with disabilities are particularly susceptible include: threats from social workers to persons labelled as having intellectual or psychiatric disabilities that their children will be taken away; threats by family members and other care-givers that the individual will be institutionalized or re-institutionalized if they do not comply with care-giver demands; threats by care-givers that they will hurt the person's pets; threats to destroy property, sometimes followed by actual destruction of property, as warnings to comply with care-giver demands; and threats to throw persons with mobility impairments down stairs.

At the very least, threats involve an unwanted invasion and disruption of the individual's well-being and reveal malevolent intent towards the threatened person. Typically, the threats are made by persons in a position of relative power. Threats are a means of coercing individuals to do things they do not freely choose to do. A threat also has the potential to escalate into actions that can cause serious physical or psychological harm.

Insults and Harassment

A variety of words, phrases and gestures were perceived by respondents as disrespectful and affronts to human dignity. Insults and harassment reported include: taunts from strangers on the street; intimidation by strangers; being yelled and shouted at by neighbours; "teasing people who can't talk right"; "talking down to" and treating as unintelligent; treating someone who has a physical disability as if the person has an intellectual disability; belittling, verbal onslaughts and general lack of

respect by care-givers in special care homes and in other settings; referring to persons as "GOMORs" by health care professionals (i.e., "get out of my office room"); "bossing around"; and various forms of verbal taunting and emotional abuse by boyfriends and husbands.

In the words of one respondent, the climate of insult is present "all the time, every day". A male respondent spoke about "the persistent, ongoing violation of dignity, paternalism, lack of privacy and rudeness [which] can happen on an hourly basis if one is out on the street". Another respondent described interactions between herself and the mental health system: "They make you feel like you don't belong anywhere. They don't make you feel welcome. They don't try to help. They make you feel like the bottom of the pit. They make you feel like you don't have any place in society."

Lack of Proper Action

Several interview respondents indicated that the failure of other persons in the community to respond to their complaints of abuse and violence adds another dimension to victimization, a dimension that widens the experience of violence. The lack of proper response from family members, counsellors, the police, the judicial system and others can have the effect of making individuals feel "re-victimized". For example, the tactics of legal professionals, who in court resort to stereotypes and misinformation concerning disability to discredit the testimony of complainants or witnesses with disabilities, were depicted as traumatic and as resulting in re-victimization.

Lack of proper response can include the failure to respond at all or responses that the individual perceives to be humiliating, intimidating or inappropriate. Chapter 5 provides more detail on how others in the community fail to respond effectively to

complaints and to other indicators of violence and abuse, intensifying the experience of violence.

Definition of Violence and Abuse against Persons with Disabilities

On the basis of the interview data for this research, a working definition of violence and abuse against persons with disabilities can be constructed. Acts of violence and abuse can be defined as conscious and deliberate acts that cause, or that threaten to cause, harm. They are public or private acts that seriously violate the principle that persons with disabilities, like other persons, are to be equally valued and protected as human beings. They are acts that ignore or hold in contempt the *voice* of the affected person and that exploit a power imbalance, or that on other grounds are contrary to the free and informed consent of the affected person. Typically, these actions result in the suffering of the person affected, whether emotional or physical. Extreme violent or abusive actions can result in the injury and even death of the person affected.

Types of Action

Violent and abusive acts against people with disabilities may involve any combination of:

- physical force (e.g., beating);
- physical actions that take the form of care (e.g., administration of medications, restraint or other treatments);
- unwanted physical actions of a sexual nature (e.g., sexual intercourse or fondling);

- the denial of rights, necessities, privileges or opportunities by persons in a position to promote or safeguard the well-being of the person affected;
- patterns of communication that may not involve physical contact but which are perceived as threatening (e.g., explicit threats or stalking), as tormenting (e.g., harassment), or as insulting (e.g., "speaking down to" or using derogatory terms in conversation);
- lack of proper action (e.g., the neglect or failure to respond effectively to harmful incidents).

Characteristics of Violence and Abuse

Intentional or Systemic

Violent or abusive acts may be *committed by individuals acting on their own impulses and motivations* (e.g., the lone stalker) or they may be *committed by agents of a broader system who believe the system compels them to perform the acts* (e.g., the attendant care provider who is in a hurry to serve another client and who therefore threatens to leave a mobility-impaired person in need).

Significantly Compromised Well-Being

Significantly compromised — sometimes seriously damaged — physical or psychological well-being is a typical result of violent acts against persons with disabilities. The person affected may immediately feel violated or harmed (e.g., during sexual assault or beating) or may feel the violation of well-being some time later (e.g., after two years of self-help group therapy to heal suppressed trauma; after 10 years of ongoing insults and rejection).

Lack of Consent

Acts of violence to which *individuals do not consent as free and informed persons* include: invasive acts committed without regard for the victim's well-being; acts that involve manipulation by means of coercion, obfuscation or the withholding of information; acts that involve exploitation of the individual's physical or psychological weakness or dependency (e.g., child sexual abuse; sexual exploitation of a socially isolated individual starved for emotional contact); and acts committed against individuals who are not at full liberty to remove themselves from harmful situations. The acts may be *explicitly intended* by the offender to be contrary to the consent of the person and to breach his or her well-being (e.g., egregious physical assault); *or the acts may be carried out by inadvertence or best intentions* (e.g., the care provider who administers a traumatic form of care or treatment to a non-consenting client, believing it to be in the best interests of the individual or society; the legal professional who takes advantage of the complainant's or witness's disability in an effort to destroy that person's credibility in court, without regard for the trauma to the person).

Frequency

Violent acts against people with disabilities include *one time occurrences,* such as singular assaults. However, abuse and violence can also take the form of a *continuum or process of acts, denials or omissions* that the individual perceives as hostile to his or her well-being. An example of such a continuum is the notorious criminal behaviour pattern of repeated physical or sexual abuse by a family member. Another example is the repeated harassment and rough handling of a client by a community service provider or health care worker. A more

subtle process is the broad cultural regime of insults and denigration that individuals with disabilities experience as exclusionary, disrespectful and hostile.

Power Differential

Because people with disabilities often must rely on others for assistance, they are generally more likely than others to find themselves weaker members in a power differential. This increases their chances of being victimized. Typically, acts of violence and abuse against people with disabilities that involve a power differential between victim and offender come about because the person who has been victimized:

- depends on the offender for physical, psychological or economic support or for other necessities;
- lacks control over the actions of others who have the potential to invade, disrupt or negate well-being;
- lacks status, credibility or voice in relation to persons or systems that are in a position to inflict, prevent or ameliorate harm.

Evaluating the Definition

For the purposes of research and public education, a broad definition of violence and abuse is useful. It may increase awareness of how certain actions that escape public notice or are considered trivial or benign are considered by citizens with disabilities to cause significant harm and anguish. The definition also reflects the approach to violence against women proposed in a recent United Nations Declaration. The declaration states that violence against women includes "Any act of ... violence that results in, or is likely to result in, physical, sexual or psychological harm *or suffering* ... including threats of such

acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (United Nations, 1993).[13] Moreover, the definition is consistent with several other researchers' approaches to naming the problem (Macfarlane, 1994; Luckasson, 1992).

Notes

1. Other researchers and analysts have explored these issues as well. See, for example, Sobsey, 1994; Health and Welfare Canada, 1993b; Westcott, 1993 and 1991; Hudson in Hanmer and Maynard, 1987.

2. For other research concerning the forms of harm perpetrated in various institutional settings, see Sobsey, 1994; Hoefkens and Allen, 1990; Pillemar and Moore, 1990; Nibert et al., 1989; Pillemar, 1988; Myers and Shelton, 1987.

3. For a discussion concerning the administration of electro-shock treatment, see Hudson in Hanmer and Maynard, 1987.

4. So named after Michael Faraday, the scientist famous for his discoveries in electricity and electrochemistry.

5. See also Weitz and Kingston in Burstow and Weitz, 1988, and Stainton in The Roeher Institute, 1988b.

6. The problem of sexual offences against persons with disabilities has also been examined in other research: Sobsey, 1994; Health and Welfare Canada, 1993a; The Roeher Institute, 1993a; Ticoll and Panitch, 1993; Stimpson and Best, 1991; Jacobson, 1989; Ridington, 1989; The Roeher Institute, 1988c; Kohan, Pothier and Norbeck, 1987; Sullivan, Vernon and Scanlan, 1987.

7. See also Sobsey, 1994; Furey, 1989; The Roeher Institute, 1988c.

8. See also Ontario, Ministry of Citizenship, 1991.

9. For other research and discussion concerning the withholding of medical care, see Merrick, 1989; Nicholson, Horowitz and Parry, 1986; Gerry, 1985; Gostin, 1985; Rhoden and Arras, 1985; Rue, 1985.

10. The social worker has the keys to her home. The respondent indicated that she can only relax in the evenings and weekends, when the social worker is off duty.

11. See also The Canadian Panel on Violence against Women, 1993, and Health and Welfare Canada, 1993a.

12. See also Sobsey, 1994, and Westcott, 1993.

13. Emphasis added.

Chapter 4. The Disclosure and Identification of Violence and Abuse

The processes of disclosure and detection often intersect with responses to violence because those who become aware of the problem are often those who make some form of response to it, favourable or unfavourable. Therefore, it is difficult to examine the process of disclosure without reference to the responses. However, a conceptual distinction between disclosure or detection and response to violence has been drawn because if the survivor cannot disclose the problem or if others cannot detect it, there will likely be no response or the response will occur by accident. This chapter explores issues of disclosure and identification. Chapter 5 provides a focused analysis of responses to the problem once it has been identified.

Many factors affect whether people with disabilities disclose incidents of victimization and how others might identify the problem when it is unreported. The factors range from whether the survivor attaches significance to the abusive act and has the confidence to report it, to whether the survivor has access to a trusted person in the community to hear the disclosure. Whether individuals feel they will be believed and supported or further harmed can also affect whether they tell their stories. The capacity of others in the community to identify a harmful

incident hinges largely on whether community members anticipate that abuse and violence might be taking place and are alert to signs of the problem.

The interview data suggest that individuals are generally better able to come to terms with being victimized if they draw upon someone else's assistance rather than rely entirely on themselves. The research identified many situations in which victimized individuals told others about the incidents so they could obtain assistance. There were also situations where other people incidentally found out about the victimization and took immediate supportive action. However, in many other cases, a great deal of time elapsed before individuals felt comfortable making a disclosure. In a few instances, an interview for this research was the first occasion on which individuals felt comfortable doing so.[1]

Who Is Involved in Disclosures and Detection?

People with disabilities who have been victimized typically have recourse to the same persons and agencies as survivors who do not have disabilities. These include family, friends and neighbours, doctors and nurses, crisis lines, community and family centres, other counsellors in the community, educators, religious leaders, the police and lawyers. Women can also contact shelters, transition houses and women's centres. In some cases, individuals disclose to others what has happened; in other cases, persons in the family or the community find out about the problem incidentally.

A special cross-tabulation prepared by the Centre for Justice Statistics, using the Violence against Women Survey data (1994), indicates the magnitude of disclosures to the police: 13

per cent of females with disabilities who have been assaulted or sexually assaulted at some point in adulthood have reported this to the police — roughly equivalent to non-disabled women (14 per cent). Whether this pattern generalizes to include adult males with disabilities is not possible to determine without analysing the most recent General Social Survey data on personal risk, an undertaking that could not be completed within the time frame of this research.

Concerning disclosures to social service agencies, the Violence against Women Survey data indicate that 12 per cent of women with disabilities who have been victimized in their adult lives have sought access to social services for assistance.[2] This is a higher proportion than among women without disabilities, where only 8 per cent have brought violent or abusive incidents to the attention of social services. Because of their reliance on social services for disability-related needs, many persons with disabilities encounter an additional layer of individuals and agencies that have either formal or informal responsibility to field complaints of violence that persons without disabilities are not as likely to encounter. This disability-specific layer of potential respondents includes social workers, psychiatrists and other therapists, institution ward staff and management, and staff and management of community agencies that provide transportation services, attendant and homemaker services, communication services (e.g., sign language interpretation), supported and sheltered employment services and advocacy services. The greater involvement by persons with disabilities with the world of social services may help explain why there is a higher reporting rate to social services among women survivors with disabilities than among those without disabilities.

The additional layer of persons and agencies in a position to respond to reports can facilitate, but can also complicate,

the often uncomfortable process of disclosure. Agencies may have in their employ the very persons who are responsible for abusing persons with disabilities.

Factors Affecting the Reporting of Abuse and Violence

Perceived Significance of the Incident

Whether individuals perceive that incidents of violence against them are significant has a bearing on whether or not they disclose the incidents. Nationally, the dominant reason why ever-married women do not report wife abuse to the police is because they perceive the incidents to be "too minor"; this is also the second most frequently given reason why they do not bring such incidents to the attention of social service providers (Statistics Canada, Centre for Justice Statistics, 1994c, Table 8 and Figure 4).

Although most interviewed survivors had made disclosures to others, several indicated that they had not told others because they did not consider the incidents serious enough. Events depicted as violent, but not as serious enough to disclose, include an incident in which an individual with an intellectual disability was repeatedly sexually abused by a volunteer in a special program for people with disabilities. The individual felt uncomfortable about what was occurring but did not seem to understand the significance of the volunteer's actions until he eventually told his mother. The mother's reaction evidently impressed on him the seriousness of the situation. Another individual chose not to lodge a complaint with the police concerning being "picked on" by his employer because the incident "wasn't big enough".

Whether males with disabilities are more or less likely than females to consider acts of violence against them as unworthy of special attention cannot be answered on the basis of the research data. One respondent commented, "Men don't see themselves as being used — taken advantage of. Men don't ever complain." Other respondents, however, indicated that they were fielding significant numbers of complaints of sexual violence against males. It can be established that, during the interview selection process, it was more difficult to identify males than females who felt comfortable talking about violence against people with disabilities. This may be due to several factors: a) males with disabilities may be less likely than females to be victimized; b) males may be more embarrassed about the problem than females and more reluctant to talk about it; c) males may be concerned about homophobia and, therefore, suppress information about sexual abuse and violence against them; or d) males with disabilities may encounter different forms of violence than females, attaching less significance to them.[3]

Research data indicate that some people with disabilities have been socialized in an ongoing climate of degradation and violence that has affected the significance they attach to particular acts. Interviewers for the research considered it probable that some people with disabilities may have become so accustomed to forms of violence most other citizens would consider serious that they see only the most egregious acts against them as worthy of special attention and possible disclosure. For example, incidents of sexual assault and sexual abuse may completely overshadow, in the individual's mind, the seriousness of the ongoing emotional and physical abuse they have experienced since childhood. As a result, they may be more likely to talk about the sexual assault and less likely to talk about the other forms of violence.

Several respondents explicitly confirmed the impression of interviewers, indicating that the general climate of violence and degradation to which many persons with disabilities are subjected alters how they construe actions towards them. In the words of one woman who as a child was repeatedly sexually abused by her foster father and emotionally abused by her foster mother, "It could be worse — I could have been beaten up or abandoned ... I have no regrets. You have to be positive to survive." One informant felt that an individual's denial, lack of education, social isolation and segregation, fear of reprisal, fear of losing disability-related services and preoccupation with financial and basic care issues, all conspire to overshadow the significance of violence and abuse when it occurs.

In several instances females indicated that they had not disclosed wife assault against them because of their commitment to their marriage vows. They understood commitment to marital fidelity to mean silently bearing their marriage partners' violence and abuse. Although they seem to have regarded the marital violence as significant, they did not consider it significant enough to bring to the attention of others for assistance.

Religion was also a factor that kept some individuals from disclosing the violence they experienced. They felt that it was their religious duty to bear silently their tribulations and the religious meaning derived from this process was more important than any impulse to tell others what was happening to them.

If the significance that the individual attaches to an incident affects whether they disclose it, so does the significance attached to it by others. Several interviewees said they had not informed the police about violent incidents because they felt the police would not have considered the incidents worthy of attention. Typically, these were situations of emotional abuse and harassment that were related to disability but did not involve

physical harm. However, there were exceptions. For example, an interviewee who had been traumatized and subjected to rough handling by a health care professional did not bring the matter to the attention of the police because the health care professional did not actually hit her. The respondent felt that the incident could therefore not be portrayed as serious enough to trigger a police response. She did bring the problem to the attention of the hospital administration. In another situation a respondent had been severely scalded by an attendant and made an initial disclosure to a lawyer. The lawyer advised that nothing could be done about the matter. In effect, the lawyer down-played the significance of the event, with the result that the individual did not bring the matter to the attention of others, such as the police. An officer later advised him that the police perhaps would have treated the incident as an assault, had he reported it. In another case, an individual who felt he had been abused in a health care setting received similar counsel from a lawyer and took no further action because he was persuaded that the incident was not a police matter.

Probability of Being Believed

The process of disclosure is affected by whether an individual feels he or she will be believed. For example, a young woman who was subjected to repeated sexual abuse in a foster home indicated that she had thought about telling someone. However, she did not tell anyone in the community at the time because she was young, had a disability and did not think anyone would believe her. Another person thought about bringing her victimization to the attention of sheltered workshop personnel, but did not out of concern that they would think she was lying. Another individual tried to talk with friends and counsellors about incest, physical abuse and neglect in her family, but was not believed. One survivor said, "I don't want to tell my family. They wouldn't believe me anyway."

Concerning the police, a respondent reported, "I was really scared to talk to them. They should have believed me and put him [the perpetrator] in jail. They just warned him to stay away from me." This woman continues to live in fear that the perpetrator "might bang [her] head against the wall". Another interviewee indicated that the police officers who initially took the complaint were supportive and seemed to believe her story. However, the team of investigating officers who later became involved were extremely sceptical. Still another survivor, with a psychiatric disability, felt that, in light of her history of mental health problems, the police were not likely to believe her should she disclose her husband's physically violent abuse of her and her children.

Several incidents of violence were studied in which the police and courts found individuals with intellectual disabilities to lack credibility precisely because of their disabilities. Other instances were identified where the police seem to have trusted the credibility of the complainants but felt the courts would not and therefore dropped, or refused to press, charges.

These are by no means isolated examples of a basic paradox. Societal attitudes tend to reflect a paternalistic and sometimes overprotective attitude towards people with disabilities. However, these attitudes do not translate into ready acceptance of the stories of people with disabilities when they claim to have been victimized.

To what extent are people with disabilities disbelieved when disclosing violence and abuse against themselves? To what extent has the experience of being disbelieved been *talked up* within the disability community? To what extent does the perception that survivors with disabilities will not be believed influence survivors when they contemplate disclosing violence against themselves? What impact does this perception actually have upon disclosure? These are disturbing questions that cannot be settled by this research study. However, the research data indicate that complaints are often greeted with disbelief.

Physical Means of Communication

Lack of physical contact with persons who can receive complaints is an obstacle to disclosure encountered particularly by individuals with mobility impairments. For example, it is difficult, if not impossible, for wheelchair users to enter architecturally inaccessible police stations, women's centres and other offices of counsellors and social workers. This can impede disclosure of victimization, particularly if the survivor wants direct personal contact with another human being while telling his or her story.

Lack of access to technical devices that can serve as a bridge between survivors and others in a position to help was identified as a further problem that can hamper disclosure. In principle, even an individual with a mobility impairment should be able to contact the police or other agencies by telephone. However, interviewers heard of instances where telephone access was blocked by perpetrators. This left victims, especially housebound ones, with few options for making their situation known to others. One situation was reported in which an abusive male blocked his wife, who has a hearing impairment, from communicating with individuals outside the family by taking away her Telephone Device for the Deaf. The woman was held virtually captive in her own home, was physically abused and lacked the technical means to make her situation known to others. Individuals with speech impairments, who have literacy skills and who are in situations where they are not completely captive to their perpetrators, would likely be able to disclose victimization to others through handwriting or sign language. Nonetheless, it was found that an abuser can temporarily, if not altogether, silence an individual. An example was given in which the perpetrator removed the speech synthesizer used by the person victimized to communicate.

Communication Skills

Several respondents indicated that limited communication not only supports victimization, but can also impede effective disclosures and responses to victimization. In the case of survivors with limited communication skills, it can be crucial for those who respond to disclosures to be able to interpret their stories. When the individual has a hearing or speech impairment and uses sign language or a symbolic communication system such as Bliss, the appropriate interpreters need to participate in the disclosure. In large urban centres this is often a straightforward logistical procedure. In less densely populated areas, however, services likely are non-existent. This complicates, and can hamper, the disclosure.

In situations where survivors have an intellectual disability that affects their spoken communication, interpretation is more difficult. If the individual has a highly idiosyncratic way of communicating, a family member or trusted advocate may be able to interpret. Such support was instrumental in assisting several respondents to disclose violence against them. However, these interpreters may be difficult to locate. In addition, the person responding to the complaint — a counsellor, police officer or lawyer — may have reason to believe that the interpreter is distorting or embellishing what the complainant is saying. In that situation, the person responding may not have confidence in the complainant's story and the survivor may feel inhibited about continuing with the process.

Persons with visual impairments can face similar difficulties. In one reported incident, a blind woman attempted to communicate to police the details of a violent act against her and to describe the perpetrator. Since the police were not skilled at using non-visual information for identification and apprehension such as details about the perpetrator's odour and voice, they were effectively unable to receive the complaint and did not pursue the matter.

In short, any individual whose disability results in limited communication skills is at risk of not being able to effectively disclose victimization and of not having their complaint taken seriously. This problem increases the risk of being victimized.

Confidence and Strength of Purpose

Whether survivors with disabilities disclose incidents of violence and confront their perpetrators can hinge on their self-confidence and personal resilience. However, there are innumerable social barriers and negative social attitudes towards people with disabilities (and, particularly, women with disabilities) that inhibit the development of self-esteem and confidence. The lack of self-confidence can discourage people with disabilities from telling others about traumatic incidents and from taking other steps necessary to resolve the problem, such as asking the police to press charges. For example, in an incident of sexual assault a survivor did not contact the police because, she remarked, "I was scared about all my life being brought out in front of someone." Several other interviewees echoed this concern.

People may also have to set aside feelings of shame, embarrassment and demoralization that result from being victimized before they feel confident enough to bring forward their complaints. Statistics Canada has found that 6 per cent of women in violent marital relationships who did not bring assault to the attention of social services were inhibited by feelings of shame and embarrassment; 5 per cent did not bring the problem to the attention of the police for the same reasons (Statistics Canada, Centre for Justice Statistics, 1994c, Table 4).

The research found that shame and embarrassment also prevent people with disabilities from disclosing abuse and violence. Several respondents indicated that males with disabilities who had been sexually assaulted by males feel

particularly ashamed to disclose the problem. "If you're a man, you take your knocks," said a respondent.

Several survivors indicated that, before any action was taken, they had to tell numerous people, on different occasions, that they had been victimized. This was frustrating and discouraging. The complexity of the "social safety net" that supports many people with disabilities may mean they have to make multiple reports to multiple response agents — a problem not as common to people without disabilities. Bureaucratic red tape and bungling were sometimes cited as impeding the disclosure process. In other situations, interview respondents indicated that the prospect of undergoing the court process discouraged them from making a complaint.

Having the support of others while disclosing victimization was, in several instances, a factor that gave survivors strength to bring forward their complaints. Informal support of this kind can be provided by a diversity of people, including family members and friends, peer self-help group members, police, physicians, counsellors, educators and advocates. However, it is reasonable to assume that many people with disabilities would lack these informal supports because they are disproportionately more likely than others to live alone and have little, if any, social contact with others.

Someone to Report To

When individuals with disabilities have the means and skills to disclose victimization and have the confidence and resolve to do so, they must first perceive that someone is available to field their complaints. In many situations researched for this report, survivors first disclosed incidents of violence to family members and friends. In other instances, family members and friends were the first to find out incidentally by seeing bruises, other physical marks and behavioural changes. When the perpetrator was not a

family member (e.g., a father), family members in many cases took steps to have the problem addressed.

If the offender is a family member, individuals may be unwilling to tell other family members about being victimized. They may fear reprisal from the offender or harassment from other family members. They may also feel concern that the family could be compromised and innocent members harmed in the process. Reluctance to disclose to other family members can also arise from the individual's concern that, because of the disclosure, he or she will have to leave the family home and lose social, economic and disability-related support.

When the offender is a care-giver in a residential, health, mental health or other setting specifically designed for people with disabilities, persons who are victimized may notify other staff or the administration. Several examples of this were given during the interviews. However, survivors are also reluctant to disclose for fear of retaliation from the perpetrator and harassment from other staff.

Individuals facing violence from family members or care-givers and who feel they cannot disclose to others in their immediate environment have two options: remain silent or disclose to others in the community. However, there may be no one available in the community to hear the disclosure. Nationally, 14 per cent of ever-married women who have been abused by male partners and who have chosen not to bring the problem to the attention of social services indicate that there are no social services to which they can turn for assistance (Statistics Canada, Centre for Justice Statistics, 1994c, Table 4). This problem also affects people with disabilities. "There is no place out there for people. I even tried through a ... church. I did look. I did try," said a respondent.

In addition to formal community organizations and agencies, self-help groups can be instrumental in enabling survivors to disclose acts of violence. Helpful groups include self-advocacy organizations such as People First, independent living support groups, consumer mental health peer groups and various women's support groups. Small seminars and discussion groups relating to sexuality also provide a context in which disclosures are sometimes made. In several reported examples, an initial disclosure by one participant triggered subsequent disclosures by others.

Accessible Supports for Reporting

Persons and agencies that field complaints of violence and abuse may not be accessible to persons with disabilities. Interviewers heard of several incidents where females who had been abused by male partners would have taken refuge at a women's shelter and were prepared to tell their stories to shelter counsellors. However, they could not do so because the shelters could not provide attendant support for survivors with physical disabilities and the individuals had no means of arranging for support to be brought into the shelter. The hours of operation of community agencies can also be a barrier to reporting abuse. Many agencies close in the evenings or on weekends, leaving an individual nowhere to turn during these times.

Some individuals with intellectual disabilities may prefer to have access to counselling services to make a disclosure. However, those services may lack the capacity or the will to interact with such survivors. As one interviewee pointed out, "There is a feeling with some therapists that because they don't work with mentally handicapped people they *can't* work with mentally handicapped people and that's not true. As difficult as it is to counsel mentally handicapped people, a lot of times it just takes more time. But it can be done."

Affordable Supports for Reporting

Agencies that hear disclosures and provide support may also be too costly. Several interview respondents indicated that private counselling services were among the most helpful that they had encountered. However, the hourly rates charged by professionals in these agencies are typically not covered by public health insurance and can be too expensive, especially for people with low or pension incomes. "Unacceptable" was the term used by one interviewee to describe this situation. In other instances, individuals may be receiving services from a rehabilitation centre or institution. Upon victimization, the centre or institution may contract counselling services from a community agency on the survivor's behalf. However, the cost to the centre or institution may be perceived as too high and the counselling arrangement is sometimes terminated before the individual can make a full disclosure.

Survivor Knowledge of the Community

Not knowing where to turn for help can make it more difficult for a survivor to make a disclosure to people outside the family or immediate circle of acquaintances. Sixteen per cent of ever-married women, who have been abused by their male partners and who have not turned to social services, indicate they do not know about available social services that might assist them (Statistics Canada, Centre for Justice Statistics, 1994c, Table 4). Given the social isolation of many people with disabilities, it is reasonable to assume that many would have less knowledge than others about agencies in the community that assist with disclosures of violence.

Clear Procedures for Making Complaints

It is important that roles and responsibilities for fielding

complaints be clear. For example, one research participant felt that attendant care providers should be mandated by management to hear and act upon disclosures because attendants have electronic paging devices and are able to respond quickly to emergency calls. The police response to emergencies was seen as slower, increasing risks to vulnerable individuals. Attendants, however, resist the idea of intervening to hear about — and perhaps to break up — violent incidents. They feel they lack training to assume this role and they are concerned for their own personal safety if a perpetrator retaliates. To whom should individuals report incidents of violence immediately?

Several interview respondents emphasized the importance of people with disabilities understanding the procedures for reporting incidents of violence. Evidently, many individuals do not have this understanding, a point confirmed by individuals who indicate that they had been victimized but did not know how to make a complaint at the time of the incidents.

Empathy and Trust

Regardless of whom survivors choose to contact to make their disclosure, it is clear that trust is crucial. Speaking of group home residents, an interviewee commented, "It takes a lot of trust before they'll tell someone." Another interviewee remarked, "I think there are lots of people out there who are still getting it done [i.e., being victimized] but they don't speak out. They don't have people that they can trust."

Survivors who felt satisfied with how their disclosure had been handled said that the response agents — social workers, counsellors, advocates, police — had showed empathy and support. The emotional climate of empathy and support helped to establish the trust necessary for disclosure.

An example of the opposite circumstances — not conducive to telling about violence — was provided by an interviewee

who felt he had been abused in a health care setting: "They didn't listen to me. They think I'm stupid. They left my clothes on and didn't change me for a week. My feet were rubbed raw. I spent several nights screaming. They finally put me in a private room. Only one nurse seemed to care." This individual had no confidence in the will or ability of the hospital staff to listen to, or address, his complaints.

Some interview respondents spoke with anger, sadness and frustration about being blamed by family members for acts of sexual violence that had happened to them. Others spoke about the sometimes intimidating appearance of police officers that can make survivors feel uncomfortable while disclosing situations of victimization.

Perceived Consequences to Safety and Well-being

In a number of reported situations it was found that, upon disclosure of victimization, individuals with disabilities were subject to retaliation by their perpetrators. Several individuals also indicated that threats and concern about reprisal from their perpetrators were factors that inhibited disclosure in the first place. A respondent recalled, "He said it would be worse if I told and 'You're a liar.'" Another, who was abused by her male partner, said the perpetrator warned, "If you charge me you will be writing your own obituary."

In all probability, actual retaliation and the fear of retaliation create mutually reinforcing disincentives for survivors to tell their stories. This is especially likely to be the case in congregate settings where several people with disabilities occupy the same social space as the perpetrator. For example, if a person with a disability witnesses, or hears about, a perpetrator retaliating against a survivor upon disclosure, there is a disincentive for that person to disclose if they are victimized by the same

perpetrator. As one respondent commented, "They [survivors with disabilities] know they'll still have to live there if they tell."

The perceived safety and well-being of others was also found to be a factor that inhibited disclosures. Several survivors indicated that their concern that the family unit would be broken up if the father was charged with an offence discouraged them from disclosure. Alternatively, the survivor's concern for others can encourage disclosure. Several interviewed survivors reasoned that, by telling about the violence, steps would be taken to deal with the perpetrator, which would protect others. One interviewee who had taken this course of action remarked, "I don't want this to happen to anyone else again."

Concern about the possible loss of personal liberty upon disclosure can also deter people from coming forward with their story. Several respondents said family members often respond to disclosure by overprotecting individuals, denying them the opportunity to venture freely into the community. Even individuals with significant intellectual disabilities are able to predict that disclosure will result in this restriction of personal liberty. In several instances, this concern was found to have inhibited survivors from talking about violence against them.

Sympathy for the Perpetrator

In a few instances it was found that the survivor's sympathy for the perpetrator was a factor that led them not to disclose violent incidents right away. They were concerned about the perpetrator's advanced age, concerned about the perpetrator's employment prospects should he or she be accused or concerned about aggravating the perpetrator's already troubled personality. For example, one interview respondent who was living in an institution was choked and pinched by one of the staff. Although the individual did bring the matter to the attention of a senior

staff person, the individual saw the perpetrator simply as a "horrible person" with deep personal problems who deserved pity rather than punishment. The survivor did not pursue the matter further.

Sometimes, individuals were disinclined to put the spotlight on their perpetrators because they feared breaking up their relationship with that person. This was found to be a factor mainly in abusive boyfriend-girlfriend and marital situations. It was also found that when the abuser is a family member providing informal support to the individual with a disability, sympathy for the abuser and concern about maintaining their relationship can be a disincentive to disclose the abuse.

Proactive Detection Measures

People with disabilities who have been victimized may have difficulty establishing contact with others and telling what is occurring in their lives or may be afraid to do so. Therefore, disclosure can be facilitated by having someone in the community who is attentive to their situation and watchful for the possibility of violence. Speaking of group home residents with intellectual disabilities, one respondent said, "Often you have to see something happen and then ask some questions. They are quite reluctant to talk about it." Another interviewee felt that "they [people in the community] should keep more eye on people or talk to people [with disabilities] — ask".

Situations were identified where service providers are trained regarding the signs of abuse and can initiate intervention by reaching out to individuals who seem to have been abused and making discrete enquiries. In other examples of detection, attentive school counsellors and teachers suspected something was wrong and queried the survivor, following which the

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individual made a disclosure. In all these situations, the individuals who facilitated the disclosure were aware of the signs of victimization and attentive to the possibility that this could occur to specific individuals with disabilities, and they actively reached out to them.

Anticipation that abuse and violence might be happening to people with disabilities and an active effort to reach out to potential victims can be critical to the detection of unreported violence. However, the research interviews suggest that this happens infrequently.

Notes

1. Most people with disabilities who had been victimized and who participated in this research — male and female — disclosed the violence at the time it happened or at some later point before being interviewed. This trend is the result of the self-selection criterion that was used to screen participants for the research interviews.

2. The data were obtained from Statistics Canada by means of a user-defined cross-tabulation.

3. If it is true that males with disabilities tend to encounter more physical violence and less sexual violence than females, then, given male socialization, males with disabilities may be more inclined than females to rationalize such incidents as normal cultural occurrences and to attach less significance to them.

Chapter 5. Responses to Violence and Abuse

Factors that shape the responses to survivors include the availability, accessibility and affordability of supports in the community. Do others have a sense of responsibility and have they developed the competence to deal with the problem as it specifically affects people with disabilities? Whether and how community members respond to the problem hinge, in part, on how this question is answered. The degree to which individuals and agencies in the community collaborate to provide coordinated responses and the procedures for doing so are other critical factors.

The police response hinges — probably too much — on the sensitivity, awareness and training of individual officers. The complexity of a given case, evidentiary problems and how the officer perceives the complainant with a disability are all factors that can weigh against the complainant. The response of legal professionals and the judiciary seems to depend chiefly on their sensitivity to survivors, whether they consider acts of violence against persons with disabilities to be serious and whether they are prepared to take steps to ensure that complainants have full access to the courts.

The research generally found a variety of responses. At one extreme, survivors are met with utter disbelief and denial because they are not perceived as credible or because persons to whom they have disclosed simply cannot accept the truth of

what survivors are saying. At the other extreme, survivors are met with the emotional and practical support needed to have the problem dealt with quickly and competently. Between the two extremes, survivors can encounter sympathetic recognition that something traumatic has happened to them, but little in the way of constructive assistance. In some cases the people responding work at cross purposes, diminishing their capacity to help the survivor.

Interview data provided no systematic and convincing evidence that particular groups who respond — including family members, social workers, educators, health care professionals, attendant care providers, the police, lawyers and the judiciary — consistently respond or fail to respond in a particular manner. The responses depend on sensitivities, attitudes, willingness to believe survivors and the skills of individuals receiving complaints, as well as on procedural, regional and local factors that can determine whether entire communities have a capacity to respond in an organized way.

The Responses of Family Members

Responses by family to the victimization of a family member with disabilities were varied. Some family members were portrayed as responding to complaints with denial and anger, sometimes blaming the survivor for the events that occurred. Several interview respondents reported that this form of response seriously aggravated the anguish caused by the traumatic incident. Some spoke bluntly of the family response as another form of victimization. People who are met by a sceptical or hostile response by family members may have greater difficulty than others in working through the traumatic incidents.

In other instances, family members were reported to have personally witnessed violence or to have believed disclosures,

but done nothing about it. One respondent who had been sexually abused by her father said, "[The problem could have been more effectively addressed] if my grandfather would have taken him [her father] and talked to him strictly." The grandfather knew what had happened but had chosen to be inactive and silent. In this and in several other situations that were examined, family members colluded, perhaps unintentionally, in painful silence.

Sometimes, families react by increasing restrictions intended to protect the individual who is perceived as vulnerable. The effect of such restrictions, however, is the denial of individuals' ordinary liberties such as their freedom to go outdoors and to associate with others. This may result in resentment on the part of the person affected.

Other family members were found to give survivors positive support. In some cases, they physically removed family members who have been victimized from dangerous circumstances and actively assisted them to pursue constructive remedies by way of the police, counsellors and other avenues. This kind of caring response by family members can play an important part in the healing process.

The Responses in the Service Sector

The responses to violence against persons with disabilities in the service sector, including social services, health care and mental health services and education, mirror those within the family unit. They range from hostility and denial to empathic, pragmatic support. As with family responses, the response of others in the community can play an important part in speeding, prolonging or halting the healing process. The following discussion probes a few of the key issues that shape the responses of the service sector.

The Availability of Support

Having someone to talk to is an important condition that needs to be met for people to feel that the response to their victimization is adequate. Interviewers heard from individuals who felt satisfied with the response primarily because they had an empathic listener such as a family member, friend, social worker, counsellor, educator or police officer. Commenting on her peer support group, one respondent said, "Lots of women in that group had things like this [violence and abuse] happen to them. I talked a lot about the assault to my counsellor. It wasn't good to keep it inside myself. I put it there permanently for a while, but it's better to tell people."[1]

Service providers and other professionals, in conjunction with family members and friends, can provide significant support while survivors lay formal complaints and they can initiate or make complaints on the survivor's behalf. They can also assist a person with a disability who does not wish to make a formal complaint by initiating or supporting their removal from a dangerous situation. If a person with a disability who is experiencing violence or abuse chooses not to make a complaint to the police, service providers and others can assist by giving emotional and other support and by validating or confirming the individual's feelings.

Adult protection workers and others in similar positions can play a particularly helpful role. They can consult with individuals, inform them of their rights, support their decision on how the case should be handled and make a complaint to the police if the survivor wants. The police may be more supportive of the individual and his or her case if an adult protection worker is involved. One respondent felt that an adult protection worker's belief in the truthfulness of a complainant's story can positively influence how the police view the story.

In contrast to situations where survivors with disabilities have access to support, interviewers also heard about feelings of isolation, grief, dissatisfaction and frustration when survivors had nowhere to turn. In other instances, interviewers heard about how counsellors were ostensibly available, but had little apparent interest in listening to survivors and were instead more intent on running "pre-packaged" programs that had little to do with survivors' real needs.

Survivors may also face long waiting lists before they obtain counselling. They may then discover that the counselling is time-limited, that is, survivors may reach a point during the counselling when they are beginning to open up, only to find that they are no longer eligible for counselling services because the next person on the waiting list now takes priority.

Similarly, it was found that individuals may face long delays before gaining access to situations where their personal safety is assured, such as safe houses and shelters. There may be a lack of safe houses or shelters, or social workers and law enforcement personnel may fail to consider such places as suitable options for people with disabilities, especially women.

In some cases, the lack of access to appropriate support services reflects a lack of funding and policy commitment on the part of governments to ensure that the necessary supports are in place. Having a responsive infrastructure of services that will address violence against people with disabilities is especially problematic in sparsely populated areas, which often have few, if any, services to assist the general population, let alone survivors with disabilities. Fiscal constraints are also rolling back service availability in more densely populated areas. In the words of one respondent, "They [the provincial government] cut funding for rape crisis centres. When they cut services to mentally disabled persons and expect the public to pick up the slack they are wrong. Society won't do that."

Lack of appropriate support in the community can result in major disruptions for individuals. For example, interviewers were told of situations where survivors in remote communities were sent to institutions in major urban centres because there were no perceived alternatives in their home communities.

The Affordability and Accessibility of Support

The affordability of counselling services can be a critical problem. Several respondents indicated that the counselling services most appropriate for their needs are privately financed, meaning survivors must personally pay for the counselling. For individuals on low or fixed incomes, the cost of these services can be prohibitive.

The consequences of funding arrangements for individuals with very low incomes can be perverse. One incident was reported in which a child with a disability had been sexually abused. The child's mother was receiving welfare but the provincial welfare payments had just been cut back. This left the mother without the financial means of supporting herself and her daughter, let alone covering the costs of counselling. As a result, her daughter was placed in foster care. While in foster care, however, the daughter had access to money and other benefits. The mother argued that these dollars should have been available to the girl within her natural family so that she could remain with her mother and have the counselling she badly needed.

The preceding chapter also looked at how the inaccessibility of support services in the community makes it difficult and even impossible for some survivors to disclose violence or abuse. Needless to say, supports that are inaccessible will be of little help in assisting survivors to work through the trauma of violence and abuse.[2]

The Clarity of Procedure

Policy and procedures of service providers help to create better awareness among staff persons of staff behaviours that will not be tolerated because they are abusive or violent. For example, a nursing centre in Winnipeg defines abuse as any act or omission that jeopardizes a resident's well-being or results in physical or mental harm, neglect or violation of a resident's rights. The notion of abuse includes physical, psycho-social, financial or material neglect, as well as sexual abuse. A step-by-step protocol of immediate and longer term measures guides the interventions of administration and nursing staff in reference to the resident and alleged abuser. The policies and procedures of several large facilities in Ontario make similar provisions in the event that abuse has been detected or alleged. The personnel policies of a large facility in Saskatchewan include in its definitions of physical, verbal and other abuses a wide range of negative conduct. The actions enumerated are qualified by the phrase "may include, but are not limited to". Again, these definitions can put staff persons on notice and provide ample scope for the detection and response to many acts that persons with disabilities perceive as offensive.

Several smaller community agencies have clear guidelines concerning the detection and investigation of, and response to, violence against clients with disabilities. These guidelines can facilitate detection of criminal abuses such as physical and sexual assaults, as well as incidents that are not considered criminal matters in law, but which people with disabilities are likely to find offensive such as verbal taunting and excessively rough handling by care-givers. It was found that, upon substantiation of complaints, the administrators of these agencies have many options including reprimanding perpetrators, terminating their employment or transferring them to other positions and notifying the police.

Service agencies have in some cases formalized their relations with the police and can quickly refer serious matters to police attention. Some agencies are also able to engage police support to guide the internal investigation of alleged incidents so agency personnel do not contaminate evidence, jeopardizing the case should it proceed to court.

In some places where clear agency protocols are not in place and where these have not been prescribed by provincial statute or policy, professionals have developed, and adhere to, their own professional guidelines for responding to complaints of violence and abuse. If the reporting of violence and abuse to public authorities is not mandatory, professionals may advise survivors about the option of bringing their case to police attention and will offer to provide support to survivors should they choose this route. One counsellor stressed that she would not under any circumstances violate a client's wishes by contacting the police without the individual's consent.

However, explicit policies, even while proscribing abuses, can leave unclear just what will and will not be considered abusive practice. For example, a large Ontario residential care facility's statement of resident rights intends to protect residents from physical, mental and emotional abuse. Included in the notion of abuse are harsh communication by words, tone of voice, gestures and deeds that are "inflicted" upon residents. Yet such actions may be allowable "within reasonable limits", provided they are part of an approved program plan.

Many agencies have not adopted a proactive position on violence or developed guidelines or procedures to deal with the problem. Although there may not be hard and fast organizational requirements, some administrators of service organizations at least seem to understand the options they *can* pursue when persons in their care have been victimized. However, in other cases, administrators do not seem to have even this basic

knowledge and take no action whatsoever. Some administrators probably know what course of action they could follow but fail to do so, perhaps to save face or for other reasons.[3]

Indeed, the research uncovered a peculiar situation in the absence of clear policy and procedures in community service-providing agencies. Several social workers attached to a large care facility were interviewed and reported that they were in the anomalous position of fielding an alarming number of calls from community-based group homes and other service providing agencies. The agencies and group homes appeared unknowledgeable about how to proceed with clients who had been abused. The community organizations were evidently grappling with significant levels of abuse and violence against clients with disabilities. The large care facility had developed its own internal protocol regarding violence and abuse and the social workers were often called upon to share information about the protocol with others outside the facility. As one of the respondents described the situation, "The number of service providers who call us to ask what they are supposed to do or to ask whether or not something constitutes abuse is alarming. It's so clear: you have the victim and perpetrator and you call the police. But this ignorance makes us wonder how many times we are *not* called and it's swept under the table." It is disturbing that the community agencies seeking help were in fact operating under reasonably clear provincial policy, which outlines what should be done when abuse or violence occurs in ministry-funded or -licensed settings. Constructive policy measures are no guarantee that those charged with responsibility for understanding and implementing policy actually do so.

Community Ownership of the Problem

In many communities, there are agencies and organizations that can respond to victimization; however, these agencies and

organizations will not universally respond to cases that involve violence against people with disabilities. A respondent observed, "Those who understand sexual abuse ... are not able to deal with people with disabilities; those who understand working with people with disabilities ... do not know how to refer or counsel or make any response to sexual abuse."[4]

Respondents pointed out that, when agencies or informal support groups have not assumed responsibility for addressing the needs of people with disabilities, social workers, the police and others mandated with a public safety role may deem institutional placement the most suitable option for persons with disabilities who have been victimized. However, the interviews conducted for this research as well as the research literature more generally indicate that institutions are sites where re-victimization can occur.

Penalties

The research found that some service providers (e.g., attendant care-givers and educators), who had been reported to administrators as perpetrators of violence and abuse against people with disabilities, were not terminated from their employment but were instead assigned to different positions. In some instances, they were assigned to jobs where they were in a position to commit similar offences. The problem may have been that the administrators had insufficient evidence to bring the matter to police attention or to fire the employee without being open to the charge of wrongful dismissal. Police respondents, however, indicated that administrators may be saving face rather than taking appropriate action. Whatever the reasons, respondents expressed frustration with situations in which administrators of agencies and institutions take little or no action against alleged perpetrators, leaving the impression that rights of alleged perpetrators ultimately take precedence over those of survivors.

Interview respondents also indicated that when no action is taken against alleged perpetrators, the perpetrators have remained in jobs where they can, and in some cases do, continue victimizing individuals who depend on them for services. Survivors have few options but to flee to other situations for safety and for the supports and services they require. One respondent, whose child had been victimized, asserted, "The staff person was being protected. The system is designed to protect the staff and agency."

Provincial ministries have closed residential care facilities such as group homes where charges of abuse have been substantiated. However, it was also reported that some facilities, after being closed, have reopened with the same staff under different names and new licences.

The Nature of Professional Solidarity

Professional solidarity can be a double-edged sword for persons with disabilities who have experienced violence and abuse. Professionals who are concerned about the reputation of their profession, not to mention justice for survivors, may urge individuals with disabilities to report incidents to the appropriate authorities. These professionals may provide survivors with emotional and moral support in the process. The research identified situations where this sense of professional ethics guided the responses of educators, physicians, care providers and others.

On the other hand, the instinct for collective survival can cause professionals to close ranks; survivors then find their problems compounded when they make a disclosure. For example, in several civil cases that did not involve the police and in criminal cases in which the police were involved, unions in the health care and social services sector launched grievances against managers who had dismissed alleged perpetrators from

their employment. In one reported action of this kind, the union successfully pressured management to have the alleged perpetrator reinstated in his previous job. In making disclosures, survivors faced possible retaliation by their perpetrators, and also pressure and harassment from the union membership generally. In one reported example, a senior staff person, who reviewed an allegation of abuse, was requested by the union to determine whether the individual who experienced abuse was a "troublemaker".

Several other situations were described in which staff failed to report incidents they had witnessed in which other staff persons were the perpetrators. It is not clear whether this was a result of employees deliberately closing ranks or fear of the consequences of whistle blowing, or both.

The Presence of Effective Advocacy

Interviewers heard that some community advocates for persons with disabilities have a clear idea about how to proceed in the event of victimization and can play an important role. For example, advocates sometimes provide constructive support to survivors during medical examinations and help prepare them for the sometimes daunting prospect of speaking with the police. Moreover, it was reported that police may be more supportive when a professional actively advocates for the credibility of a complainant than when advocacy support is not present. In these situations, the credibility of the advocate seems to rub off onto the complainant.

Survivors' lack of access to effective advocacy support can impede appropriate community responses to violence. A respondent said, "They [a family of a survivor with a disability] have had no help in any way through all of this. Whenever they try to get an advocate, they are told that 'we do not handle

this'. No patient advocate ever shows up." Several other respondents pointed to the absence of effective advocacy as a critical problem that leaves many survivors with disabilities fending for themselves.

The important qualifier, however, is *effective* advocacy support. Interviewers were told about advocates who seemed at a loss as to how to proceed and who floundered in confusion when faced with a person with a disability who had been victimized. Some survivors apparently prefer to have nothing to do with paid advocates such as adult protection workers because of bad experiences with these professionals in the past.

Conflicting Interests

In some situations, conflict between the express wishes of the survivor and the good intentions of others can result in a lack of response to violence. Referring to the "very inadequate" response in a particular case, a counsellor pointed out that poor responses can occur, not because of any lack of concern for survivors or disbelief in their stories, but "because there is nothing in our laws that allows us [e.g., counsellors, public officials] to decide to press charges when the victim is an adult and the victim does not want that to happen".

Conversely, sometimes persons responding to violence against people with disabilities are overzealous in their good intentions and come into conflict with the wishes of the survivor. Interviewers heard about the importance of counsellors and other professionals respecting survivors' wishes and directions concerning how incidents are to be handled. They also heard about persons responding to reports of violence going over the heads of the survivor and lodging complaints with others, such as employers, who were in a position to deal with perpetrators. In one such reported instance, the perpetrator was fired. The

survivor was not seeking this outcome and was dissatisfied with how the incident was handled.

The mandatory reporting and investigation of abuse can create other conflicts and dilemmas. In provinces such as Newfoundland and Nova Scotia, for example, anyone who knows about a situation where an individual with a disability is not receiving proper or adequate care and attention or has been abused is bound by law to report this (Newfoundland, *Neglected Adults Welfare Act,* c. N.3; Nova Scotia, *Adult Protection Act,* c. 2). In Newfoundland, the Director of Neglected Adults and in Nova Scotia the Minister of Community Services are obligated to investigate the matter. However, a survivor of abuse may not want government agencies, social workers and perhaps the police becoming involved in his or her case, preferring to pursue less invasive remedies. In these situations, the survivor could be seen as breaking the law by asking others who know about the violence to keep the matter confidential.

Those who know about abusive situations and who set the person's desire for confidentiality over and above the state's right to know, break the law where mandatory reporting provisions are in effect. This can have the unintended effect of driving abuse underground altogether, which impairs the capacity of society to respond. For example, this research was conducted in light of legal counsel that interviewers in Newfoundland and Nova Scotia would be bound by the law to report any original disclosures of violence or abuse emerging in interviews. To comply with such a requirement would have placed interviewers in the untenable situation of breaching the confidentiality of interview respondents. As a result, in these provinces, only incidents of victimization that had already been disclosed to public authorities were studied. Researchers simply

do not know about cases that have not been reported to the authorities and have no legal way of finding out without disclosing these cases to the authorities.

Unwanted Publicity

Another factor that may compromise the survivor's satisfaction with responses to violence and abuse is the unwanted publicity that sometimes occurs after incidents are disclosed. One respondent spoke about the "circus-like" atmosphere that was created in her neighbourhood when several police cruisers, with their lights flashing and sirens blaring, arrived in response to her complaint. Another spoke about the newspaper coverage that her case received. Although her name was suppressed in the report, she was the only individual in her small community who used a mobility device, a detail that was included in the newspaper reports. She was easily identified and virtually everyone in the community knew the intimate details of the violent incident.

Factors in Institutional Care Settings

In institutional care facilities, a number of factors can lead to inadequate responses to incidents of victimization. These factors include insufficient staffing and the resulting lack of staff attention to signs of abuse. Low wages and high turn-over can create situations where staff have little interest in conducting themselves professionally in their jobs. Inadequate staff training can result in a lack of staff insight and competence concerning situations of abuse. Inadequate incentives and protections for staff to report and respond to situations of abuse involving other staff can create abusive organizational climates. In these situations, staff may be afraid of losing their job if they do report abuse or peer pressure may shame them into silence.[5]

Moreover, staff in some facilities tend to prefer managing the "disruptive behaviours" of residents rather than determining why residents act as they do and adopting more appropriate response measures. As one respondent put it, "Aggressive behaviour is a result of something else wrong, not a need for behaviour modification." Another respondent observed, "Many behaviours are not 'normal' but manifestations of sexual abuse from earlier years." Individuals who manifest such behaviours as a means of expressing anguish over their victimization can hardly be expected to be satisfied with responses to their pain that involve mechanical or chemical restraints, contingent time out (e.g., social seclusion in a special room away from other residents) and other tactics that use power and further pain to make individuals comply with their care-givers.

Many of the problems that affect the response to violence in institutional settings are also present in community service settings. This is most likely to be the case in community support settings that have adopted an institutional approach to service provision, which are managed along similar lines, and which have inherited many of the same staffing problems and problems with staff-resident relations.

Responses by the Criminal Justice System

Police

Interview respondents' views of the police response to the victimization of people with disabilities represented a wide spectrum of opinion. Many respondents — survivors and supporting professionals — said they were satisfied with the involvement of the police. This finding mirrors national data drawn from the 1994 Violence against Women Survey in which 51 per cent of female survivors with disabilities indicate that they

were either "very satisfied" (25 per cent) or "satisfied" (26 per cent) with the police response.[6] Speaking favourably, one interviewee said the police made her feel "validated" by the way they conducted their work. Another respondent felt that the police "seem more geared to believe than not believe" the stories of survivors with disabilities. A counsellor portrayed the police as respectful of complainants and other professionals and as providing good follow-up responses to complaints. These officers were members of a sexual assault team with evident sensitivity towards many issues that arise when survivors have disabilities.

It was found that the police may also take the initiative to involve members of volunteer support groups in cases where individuals have no other support. This measure was seen as especially helpful for complainants who are not connected to adult protection workers or other social workers, or who have refused assistance from these professionals because of bad past experiences with them. Police officers were, in some instances, portrayed as having used sensitive and creative investigative techniques to ensure that they gathered all pertinent evidence. Others were seen as going beyond the call of duty by personally arranging to drive survivors to their court appearances.

However, such positive views of the police are not universal.[7] Some respondents felt that the police response is typically only "so so"; another used the term "50-50". One respondent indicated that the police seemed to talk "around" rather than "to" survivors, making survivors feel incidental to the investigative process. Yet another respondent, reflecting on a particular case, remarked that the police response was influenced not by the female survivor's disability but by the perpetrator's disability: "The fact that the person who sexually harassed her was physically disabled meant that the police thought she could have got away if she had really wanted to." Still other respondents spoke about survivors receiving

empathic police responses but in the same breath reported that the police took no further action beyond gathering preliminary information and ultimately dropped the cases.

At the farthest extreme were respondents who reported a chilly police response. Several spoke about being treated with outright scepticism. One reported being advised by officers to get on with her life and she told about the failure of officers to arrange for or suggest that she seek counselling to come to terms with the traumatic incident.

Lack of police understanding concerning the relationship between gender and violence can also affect the police response to women who have been victimized. As the Canadian Panel on Violence against Women observed:

> Many women told the Panel that police officers know little about the dynamics of violence against women or take violence against women seriously. Police, mostly men working in a "tough" culture, do not relate easily to women's fear. Their overexposure to horror and violence has desensitized them to pain and suffering, and their training does not include anything to offset this. ... Many hold stereotypical views of gender, race and class and fail to understand the needs and circumstances of specific groups of women, such as young [women], women with disabilities, immigrant or poor women, women of colour or of visible minorities. (*The Canadian Panel on Violence against Women*, 1993, p. 214)

The research finding that persons with disabilities encounter a variety of police responses is confirmed by the Violence against Women survey data. The data indicate that 48 per cent of women survivors were either "dissatisfied" (19 per cent) or "very dissatisfied" (29 per cent) with the police response to violence against them.[8] Various speculations were offered as to why the police response is so varied. One research participant commented, "There are police officers who have been very, very helpful, and that's usually because they've had past experience with people with a mental handicap. And we've

had some people that just haven't had the empathy that we felt they needed, so the investigations just didn't go all that well and the information [gathered during the investigation] wasn't all that accurate." Limited officer contact with persons with disabilities and social myths and stereotypes were cited as other factors that affect the police response.[9]

Another respondent felt that the police are inclined to pursue cut-and-dried cases. Since complaints about violence against individuals with disabilities — particularly survivors with intellectual and psychiatric disabilities — may not fit this description, the police do not always pursue these cases thoroughly. For example, in cases where the lack of consent must be clearly established before the perpetrator can be convicted, the police may find it difficult to establish the survivor's ability to withhold consent or even to understand the distinction between consent and lack thereof. The police may simply drop cases where the survivor's understanding is unclear concerning consent or where a defence attorney could plausibly argue that the accused had reason to *believe* that the survivor was consenting.

One respondent indicated that the police are most likely to believe complainants who are articulate and can demonstrate that they understand the questions asked during an interview. However, not all individuals can satisfy this requirement. Some people who have an intellectual disability may comprehend quite well what is being said in a police interview but need time and support to answer. The respondent felt that the police may question the survivor's credibility in these situations.[10]

It was reported that the setting in which the complaint is heard may also influence an officer's decision whether to proceed with a complaint. For example, in settings where a number of other persons with disabilities are present, such as a group home or a large residential care facility, the credibility

of the complainant may be more likely to be questioned than in other situations. In contrast, someone who has been sexually assaulted on the street by a stranger may be seen as more credible because the police do not encounter the individual as a member of a devalued group.

Other factors that respondents indicated may discourage a police officer from proceeding with a complaint include: the survivor's rage at the incident, including their acting out of control, swearing or yelling; other unusual behaviour on the part of the survivor; a rambling recounting of the details of the complaint and inconsistent or contradictory details; slowness in speech; and, if the accused has a disability, the perception that the accused is innocent looking and could not possibly have committed the act.

Numerous interview respondents expressed frustration and anger about cases the police had decided not to pursue. However, it was found that sometimes the police may simply not know *how* to proceed in cases involving individuals with disabilities. This is due in part to inadequate police training concerning people with disabilities, a matter that has only recently been addressed on a systematic basis in Canada.[11] The problem is also due to the lack of clear policing procedure for these cases.[12] Voluntary organizations in the community can play a valuable role in helping the police carry out their public safety mandate. For example, a situation was reported during the research in which a community organization had provided the police with a protocol for handling a case that involved a survivor with a disability. The protocol served as a guide not only for the police but for family members as well. When the police did not adhere to the protocol, family members advocated for the survivor. It was also found that community organizations have provided assistance to the police and survivors during in-depth interviews following the initial lodging of complaints.

The Courts

Legal professionals may encourage and support survivors to take their complaints forward to courts of law or may discourage them. It was found that, in some situations, Crown attorneys go to considerable lengths to prepare survivor-witnesses for court and arrange for the necessary supports. It was also found that Crown attorneys may not adequately inform survivors concerning critically important matters, such as how much time the legal proceedings will take, the meaning and implications of legal details relating to the case, the types of trauma that the survivor is likely to face in court and the support that is available to survivors during court proceedings. One respondent said, "The court case was the worst experience of my life".

In several cases that went to court, the judge discounted the alleged victims' testimony. In the absence of corroborating evidence, the perpetrators were not tried on, let alone convicted of, the charges against them.

In complex situations that involve collaboration between various players, such as social workers, family members, the police and Crown attorneys, how the judiciary plays its role can make it difficult for others to realize their goals. For example, even if all the pieces are in place and the stakeholders are collaborating effectively in a case that goes to court, and even if the perpetrator is found guilty, all of these efforts are of little practical use if the judge suspends the sentence.

Where guilt is established and sentences are meted out, sentencing provisions may be weak. In the words of one respondent, who was frustrated at the inadequate sentence handed down in his case, "They [perpetrators] should be put away for that — for doing things like that in a special care home for the handicapped. He [the perpetrator] should be very severely punished." Another respondent said, "He [the perpetrator] got off blue murder." When sentencing provisions are weak, rather

than deterring perpetrators, the courts send out the message that, depending on the circumstances, it may be legally possible and acceptable to victimize persons with disabilities. This increases the many risks to people with disabilities. However, a volume of case law is emerging that suggests judges are, more and more, looking at the survivor's disability as an aggravating factor for the purposes of sentencing.[13]

The adversarial nature of the judicial process is another factor that can render the response of the criminal justice system to violence and abuse against persons with disabilities far from ideal. One respondent remarked, "In my opinion, and from my experience, you come away from the court system in worse shape — with lower self-esteem and the desire to climb back into the closet. I was lucky. I survived — barely — and I had support." This individual was not alone in having negative experiences with the criminal justice system. Another respondent spoke about being intimidated in court by the defence attorney while the public prosecutor failed to intervene on her behalf. Nor did the prosecutor pursue a line of questioning that would have helped to counter the defence attorney's strategy of discrediting the witness. Yet another respondent related, "What was so infuriating was how she [the judge] allowed this banter [of the defence attorney] to go on and on humiliating me. I was treated as guilty of having a disease [i.e., a disability]."

The inaccessibility of court facilities, rules of evidence and the questionable status of testimony provided by individuals with limited expressive communication skills are other factors cited during the research that weigh against survivors with disabilities in court.

Issues concerning the federal and provincial and territorial legislative framework to address the victimization of persons with disabilities are taken up in Chapter 6. Issues pertaining to individual legal cases are examined in Chapter 7.

Government Policy Responses

Identification of Violence and Abuse

Whether actions or omissions that harm persons with disabilities are framed as acts of abuse or violence depends in part on how these terms are defined in law and in policy. Chapters 6 and 7 examine in detail how violence and abuse have been understood in law. Although not a comprehensive review of policy provisions in all program areas, on the basis of a selective research strategy, the research found that governments create many law and policy instruments that they count on to protect people from harm.[14] However, in some areas, gaps between law and policy can create leeway for abuses to occur and go unreported. The following examples illustrate this problem.

Ontario's *Homes for Retarded Persons Act* covers administrative and financing details but makes no mention of abusive or violent care-giver actions that are forbidden. To a limited extent, provisions of the federal *Criminal Code* and the Ministry of Community and Social Services policy instrument — the Serious Occurrence Reporting Procedures document — address this deficiency. The policy document essentially mirrors the *Criminal Code*, requiring that serious occurrences be reported to the ministry and to the board or operator of ministry-licensed or -approved facilities. Serious occurrences include egregious acts such as those causing the death, serious injury, abuse and mistreatment of clients. Abuse is defined as including physical harm, sexual molestation, sexual exploitation and failure to provide necessary treatment. Neither instrument, however, makes any provision for less severe abuses that do not cause serious injury or death, but that are experienced as violent and abusive.

Children usually fare better than adults in this respect, having a more comprehensive net of law and policy to protect them. The Ontario *Child and Family Services Act* includes specific provisions to protect young people with disabilities from disability-specific forms of neglect,[15] as well as from other abuses from which all children are to be protected. Agencies funded or approved under this *Act* also fall under Ontario's Serious Occurrence Reporting Procedures. In this example, the law casts a wider net than the ministry policy document by defining the kinds of harm that could conceivably trigger child-protection proceedings. Actions proscribed in the statute include deliberate acts against a child and acts of omission by persons responsible for the child that result in actual or *substantial risk of* physical harm to the child, sexual molestation, sexual exploitation or *emotional harm.* Indicators of emotional harm include severe anxiety, depression, withdrawal or self-destructive or aggressive behaviour.

Actions that are considered completely unacceptable in some legislative and policy environments are considered acceptable in others. For example, the stated policy of Nova Scotia's Department of Community and Social Services is that aversive behaviour management techniques are neither used nor condoned in departmentally licensed or funded facilities. In contrast, various forms of restraint and segregation are considered acceptable in a number of facilities that are operated under Saskatchewan's Social Services Community Living Division.[16] Policy directives for third-party agencies (e.g., group homes) operated under the auspices of the department also allow for the use of Level III Highly Intrusive and Restrictive Procedures in some instances.[17] Level III procedures include practices such as confinement time-out, physical or mechanical restraint and the administration of what the policy manual calls

"harmless" aversive therapies, such as noxious substances or stimuli intended to startle clients and gain their behavioural compliance. Third-party agencies are left to develop their own internal policies that reflect departmental guidelines.

Some jurisdictions have no particular position on actions that could be construed as violent or abusive. Nova Scotia's Department of Health, for example, has no official policy concerning behaviour management practices. Responsibility in this area falls chiefly to the department's consulting psychologist and practising psychologists. Although these individuals were considered by a departmental official to be generally opposed to punishment-related aversive management techniques as a matter of principle, such procedures may be implemented, provided that formal prior approval is obtained from a given institution's Ethics Committee and Board of Directors.

At the time this report was prepared, the Department of Family and Social Services in Alberta was only beginning to develop policy for responding to allegations of abuse concerning people with disabilities who receive services delivered or funded by the department. The department has "departmental core standards" intended to ensure the basic safety and effective operation of services. However, it cannot be assumed that these measures are complied with in practice. As one interview participant asked, "What good were *any* standards if they are not adhered to?"

Manitoba's Department of Family Services has no single policy governing behaviour management practices. Instead, various programs and residential facilities have developed their own policies, which have been framed in light of the standards and ethics of the Canadian Psychological Association.

Measures to Coordinate Responses Within and Across Sectors

Policy concerning collaboration among various players within and across the service and criminal justice sectors can be critical to responses to violence against people with disabilities.[18] Some interview respondents explained how a variety of individuals worked together in an effective way to resolve the incidents that they disclosed, including family members, teachers, social workers, service providers, the police and Crown attorneys. In cases of alleged child abuse, government and agency policies and procedures tend to be well developed. Increasingly, there is a coordination of efforts across departmental and agency lines through mechanisms such as inter-sectoral agreements. Protocols to coordinate responses to cases involving persons with disabilities are emerging in some places.[19]

However, the absence of a coherent plan to guide the involvement of social workers, the police and other parties in making referrals and other responses is a crucial problem. It was found that the police in some communities do not have victim services counsellors and are not knowledgeable about the organizations that may be able to provide counselling services to individuals with disabilities. This is the sort of help that survivors with emotional or intellectual disabilities especially need. When the support is lacking, there is little chance that individuals will be referred to organizations that can provide assistance during criminal investigations.

Sometimes the responses to violence against persons with disabilities work at cross purposes because they are not taken within the context of a coherent, overall policy strategy. For example, one interview respondent related that she was very satisfied with the police response to her complaint. However, although the investigation resulted in the involuntary committal of her abusive partner to a psychiatric hospital, the partner was

released from the hospital due to institution short-staffing. The police had no control over the release. The abusive partner began to harass her. In similar example, the abusive partner returned from hospital to assault his female partner repeatedly.

Without inter-agency agreements — formal or informal — that bind various agencies to a coordinated response, the community's response to victimization is likely to remain ad hoc and chance will continue to determine whether survivors obtain the level and forms of support they need. It might be argued that government departments should take a strong leadership role on this front by developing inter-sector agreements and other model protocols to ensure coordinated responses to violence and abuse against persons with disabilities.

Overall, there is a pattern of inconsistent response to the victimization of persons with disabilities. Many factors shape the kinds of responses made and their suitability. But, in the final analysis, the luck of the draw seems to determine whether victims with disabilities will be responded to in a suitable manner. What emerges clearly from the interviews conducted for this research is a widespread sense of frustration and outrage among survivors and their supporters concerning society's responses to abuse and the violence. There is a prevailing conviction that justice is not being served.

Notes

1. Concerning the importance of support groups, see also Fresco, Philbin and Peters, 1993.

2. See also The Canadian Panel on Violence Against Women, 1993; Ontario Women's Directorate, et al., 1993; Turk and Brown, 1993; Westcott, 1993; Sobsey and Doe, 1991; Masuda and Ridington, 1990; Masuda, 1988.

3. On the importance of clear policy and procedures, see also The Roeher Institute, 1993a.

4. Concerning effective counselling strategies for victims with disabilities, see Mansell and Sobsey in Sobsey, 1994.

5. See also Sobsey, 1994; Rindfleisch and Bean, 1988; Sundram, 1986; Maibaum, 1985.

6. Data were obtained through a user-defined cross-tabulation prepared by Statistics Canada's Canadian Centre for Justice Statistics.

7. See also Ontario Women's Directorate et al., 1993; Stimpson and Best, 1991; Masuda and Ridington, 1990.

8. Based on a user-defined cross-tabulation prepared by Statistics Canada.

9. See also The Roeher Institute, 1993a; and Stimpson and Best, 1991.

10. Concerning police officer perceptions of victim credibility when victims have disabilities, see also Ontario Women's Directorate et al., 1993; The Roeher Institute, 1993a; Stimpson and Best, 1991.

11. For an indication of the emerging concern within the policing community about persons with disabilities, see Canadian Association of Chiefs of Police, 1993.

12. See also The Roeher Institute, 1993a.

13. See Chapter 7. Luckasson (1992) provides recommendations concerning sentencing provisions that could be implemented in the event that individuals with disabilities are subjected to various abuses that have not been framed as criminal offences.

14. A comprehensive review of policy provisions in all program areas, in every department, in each province and territory, that could conceivably be involved with persons with disabilities who have been victimized, would comprise a major study in itself.

15. That is, neglect of necessary treatment to remedy or alleviate a condition that could impair the child's development.

16. In principle, those seeking to use such behaviour management techniques must first obtain the appropriate approval. A maze of procedural safeguards have been developed in reference to specific techniques.

17. Again, certain procedural safeguards must be followed.

18. See also Sobsey, 1994; The Roeher Institute, 1992b; Straus, 1988; Wagner, 1987; Aiello, 1984-86; Aiello and Capkin, 1984.

19. See, for example, Quebec, 1992, and Nova Scotia, Department of the Attorney General and Department of the Solicitor General, 1991.

Chapter 6. The Legislative Framework

The *Canadian Charter of Rights and Freedoms* and other federal and provincial legislation establish protections against acts of abuse and violence, including acts that may not cause evident physical or psychological harm but which restrict individual liberties. In many cases, the provisions are general and are intended to apply equally to all persons, regardless of ability or disability. In other instances, the legislation draws attention to the particular relevance of disability and creates specific protections. This chapter looks at federal, provincial and territorial legislative responses to violence against persons with disabilities. Where statutory provisions are aimed at addressing violence generally, the particular relevance of those provisions to persons with disabilities is explored.

Under Canada's legislative framework, people with disabilities have ambiguous protections from the forms of violence and abuse that they are particularly likely to encounter. The status of persons with disabilities in relation to the courts is not always clear and, in some cases, the status of their testimony is placed in question because of their disability. *Criminal Code* provisions are either silent or unclear concerning various actions that persons with disabilities are likely to experience as violent, abusive, restrictive of individual rights and freedoms and harmful on other grounds. Provincial and territorial civil laws create various protections that are not spelled out in the *Criminal Code,* but these tend to be most explicit in reference to children, to adults residing in selected

care settings and to adults who are under various forms of adult protection and guardianship. These provisions vary considerably among provinces and territories and even across departmental lines within a province or territory. These pieces of legislation also tend to require severe levels of harm before violence and abuse against persons with disabilities can be framed as a matter for the courts to consider.

The Provision of Testimony

The *Charter of Rights and Freedoms* provides that "every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination ... based on ... mental or physical disability" (s. 15). The efficacy of the legislative framework in addressing violence against persons with disabilities hinges largely on the capacity of people with disabilities to avail themselves of the law's protections and benefits. In part, this means gaining access to the court system and providing testimony. For individuals who face barriers in doing so because of communication difficulties, the *Charter* provides that persons who are deaf or who do not understand or speak the language used in court proceedings, "have the right to the assistance of an interpreter" (s. 14). Section 6 of the *Canada Evidence Act* allows for a witness "who is unable to speak" to provide evidence "in any other manner in which he can make it intelligible". The evidence acts of Manitoba, the Northwest and the Yukon territories and Quebec's *Code of Civil Procedure* make similar provisions.

However, the *Canada Evidence Act* also specifies that a person whose mental capacity is challenged, "who neither understands the nature of an oath or a solemn affirmation nor is able to communicate the evidence shall not testify". This

provision is echoed in the *Evidence Act* of British Columbia and in Quebec's *Code of Civil Procedure*. These provisions seriously undermine the access of certain persons with disabilities to the courts and therefore to the full protection and benefit of the law. On the basis of Statistics Canada's Health and Activity Limitation Survey (1986), it can be determined that 19,000 Canadian adults residing in private households (i.e., not in institutions) have limitations that affect their ability to learn or remember and are completely unable to make themselves understood by people other than immediate family and friends. A further 63,000 adults with such disabilities are only "partially" able to make themselves understood by people other than family or friends. These persons may be particularly vulnerable to violence and abuse, yet may not be permitted to testify.

When individuals are able to communicate and are permitted to testify, but have an intellectual or psychiatric disability, their testimony may be subject to other limitations. The evidence acts of all provinces and territories, except Quebec, New Brunswick, Manitoba and Saskatchewan, require corroboration before any judgement can be reached in cases where complainants have a mental disability.[1]

Protection Against Harms to Physical and Psychological Well-being

Serious procedural obstacles limit the capacity of certain people within the disabled community to bring their victimization to the attention of the courts; however, these problems do not affect all persons with disabilities. Many, if not most, are technically able to bring violence against themselves to the attention of the police and courts of law and can provide testimony that will be judged on its own merits. Many legal

protections are available to such persons. However, the legislative framework also has limitations that can make it difficult for persons with disabilities to establish that others have acted violently towards them in an unlawful manner. The following discussion examines legislative provisions that identify, and in some instances limit, the capacity of the law to address the forms of violence and abuse experienced by people with disabilities.

Physical Harm

Federal provisions

Section 7 of the *Charter* prohibits violations of security of the person. This provision can and has been used to protect individuals with disabilities from unwanted invasion of their bodies.

Section 215 of the *Criminal Code* establishes the general duty of parents, foster parents, guardians and heads of families to provide "necessaries of life" for children younger than 16 years and spouses. The duty extends to people who have charge of others who are unable to withdraw themselves from that charge and provide their own necessaries of life. "Mental disorder" is specifically given as one of several reasons why individuals may not be able to so withdraw and provide for themselves. However, an offence against such persons is present only where "the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be injured permanently".[2]

These provisions of the *Code* are problematic with respect to some of the harms experienced by people with disabilities. For example, "necessaries of life" are not clearly defined, yet it is reasonable to suppose that disability-related supports may

in some situations be fundamental to an individual's life and well-being. These supports would include attendant support for persons with severely restricted bodily movement and other forms of personal assistance for persons with intellectual, communication and psychiatric disabilities. Medications, mobility devices and dietary supplements may be considered fundamental to the life and well-being of other persons. Nevertheless, it is not clear which classes of support, in what circumstances, may be essential to the life and health of a person with a disability. Therefore, it is not clear in law at what point the failure of a person, who has charge of someone else, to provide a disability-related support becomes a criminal matter.

Moreover, it is questionable whether endangerment of life and compromised health are appropriate measures of a criminal offence against persons with disabilities who are in the charge of others.[3] The *Code* considers the much lesser requirements of failing to offset destitution or "necessitous circumstances" to be offences when the duty is owed to one's child or spouse. In contrast, the former measures allow persons in the care of others to experience many harms up to the point of death or permanent injury to health.

Section 221 of the *Code* goes some distance towards addressing these problems by prohibiting "bodily harm", meaning "any hurt or injury to the complainant that interferes with the health or comfort of the complainant and that is more than merely transient or trifling in nature".[4] However, the prohibition is directed against causing significant physical harm or discomfort, which again leaves a wide margin for individuals with disabilities to be subjected to lesser physical harms, not to mention a range of psychological harms. The provision also leaves in question the seriousness of repeated acts that alone may not cause physical harm but all together are experienced

by persons with disabilities as seriously degrading, intimidating or malicious.

The *Criminal Code* protection of individuals who are unable to withdraw themselves from the charge of others is problematic on other grounds as well. Many people with disabilities do not have access to the level or form of assistance that they require. Although inadequate, the level and form of support to which individuals have access while in the care of a perpetrator may not be so radically deficient that their life is in danger or their health permanently injured. From one perspective, individuals may be considered technically free to seek out alternative circumstances if they are dissatisfied. However, on a pragmatic level, such individuals may not consider themselves fully able to leave because there are no suitable alternatives. Does apparent voluntary acquiescence to their current situation imply consent to all forms of harm done to them up to the point that their life or health are endangered?[5]

Despite these difficulties with the *Criminal Code*, successful legal action demonstrates its potential to punish egregious acts of neglect. In 1991, operators of a rest home were convicted of criminal negligence causing the death of one resident and bodily harm to another resident, contrary to *Criminal Code* sections 219 and 220 (*R. v. Berry and Berry,* 1991). One resident died as a result of scalding in a bath; the other suffered severe frostbite. The prosecution established that the operators completely disregarded the lives and safety of these two residents.[6] The prosecution also established that these residents were under the operators' charge, that the residents could not withdraw from that charge because of age, illness or other cause and that the residents could not provide themselves with the necessities of life.

Provincial law and regulations

Provincial legislation addresses some of the deficiencies of the *Criminal Code* with respect to physical harms that persons with disabilities may encounter. Children with disabilities are sometimes included within the general definition of the child for the purposes of legislation that proscribes harms such as physical abuse. In other instances, children with disabilities are explicitly referenced and accorded additional protections. For example, prohibitions are in place in most provinces and territories against failure, on the part of parents and others in a position of charge, to make provision for the necessary medical treatment and other forms of care for their children with disabilities.[7] However, these prohibitions vary considerably in specifying issues that could be relevant to the disability-related needs of children.[8] In terms of more general protection, the statutes and regulations of most provinces and territories make provision to prohibit the physical abuse and mistreatment of *any* child and create the duty to report when such activity is suspected.

Concerning children receiving services, statutory and regulatory provisions are in place to ensure that physical facilities of child care and other services for children meet basic health and safety standards. Some provincial legislation and regulations specifically prohibit service providers from depriving children of basic necessities.[9]

Most jurisdictions also impose limits on service providers concerning the physical punishment and discipline of children. Ontario's *Child and Family Services Act,* for example, prohibits the use of any physical force for the purposes of child punishment or correction on the part of foster care and other service providers.[10]

Provincial and territorial legal protections have been created to address physical harms perpetrated against adults with disabilities. The Atlantic provinces have adopted a particular, although not altogether consistent, approach to the problem through neglected adults legislation. The provisions vary from province to province but include protection against neglect, physical abuse and sexual abuse.[11] Section 48 of Quebec's *Charter of Human Rights and Freedoms* creates broader protections when it states, "Every aged person and every handicapped person has a right to protection against any form of exploitation [and to] the protection and security that must be provided to him by his family or the persons acting in their stead." Other physical safeguards that apply to persons with disabilities in this legislation pertain to life, security and the right to assistance in the event that life is in peril.

Provincial and territorial provisions have been established to protect adults receiving residential or mental health care services. As with children's services, the provinces and territories typically have enacted provisions that establish basic health and safety standards and ensure the inspection of facilities for compliance with those requirements. It is feasible that cases of egregious physical mistreatment would come to the attention of provincial authorities through this monitoring.

Provisions concerning the reporting, mandatory and otherwise, of suspected abuse extend protections to individuals covered by various statutes.[12] In addition to those legal provisions, certain events can trigger extensive investigations. For example, the death of Joseph Kendall, a resident of an unregulated boarding home in Orillia, Ontario, sparked the appointment of a Commission of Enquiry under the *Public Inquiries Act*.

In addition to basic health, safety and reporting measures, other safeguards are in place to protect certain categories of adults with disabilities from physical harm. For example, adults who reside in Ontario nursing homes are legally entitled to "the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs", according to Ontario's *Nursing Homes Act*, 2(2).[13] In Newfoundland, anyone who wilfully *causes* a person to become neglected, either through committing or omitting an action, is guilty of an offence under the *Neglected Adults Welfare Act*, s. 11. The punishment, however, is paltry for those convicted: a maximum of $200 fine and/or two months in jail.

Generally speaking, the strongest safeguards against violence and abuse affecting adults with disabilities are embedded in neglected adult and adult protection legislation and in legislation governing persons residing in various residential care settings. Other than the *Criminal Code*, there are few legislative safeguards against the physical harms that affect individuals with disabilities living in ordinary homes in the community and who have not been deemed *neglected* or *in need of protection*. The latter two classifications, in effect, require the individual to surrender ordinary liberties in exchange for protection from harm.

Psychological Harm

Federal provisions

A particular example of psychological harm is addressed in section 269.1(2)(d) of the *Criminal Code*. This provision depicts "torture" as "any act or omission by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person" because of discrimination or in order to obtain

information, inflict punishment or to intimidate or coerce. The intent of these provisions, however, is to stem political acts of torture committed or instigated by "officials" of the state. It is difficult to see how persons with disabilities could avail themselves of these provisions to address psychological abuse by others.[14]

Criminal Code provisions that treat various assaults and sexual offences implicitly recognize the psychological harm to the victim, where physical injury is not caused but where the victim has not consented to sexual actions. In addition, the law's prohibition of the abuse of authority and trust in such situations implicitly recognizes the psychological harms created by these actions (see below).

Provincial law and regulations

Provincial and territorial law proscribes more clearly than the *Criminal Code* various psychological harms to which persons with disabilities may be subjected. As with provisions to address physical harms, many protect children.[15] In some instances, the protections for children with disabilities are general and do not necessarily require, as a criterion of psychological harm, evidence of permanent psychological injury.[16] Concerning children receiving services, a diversity of provisions are in place to prevent psychological harm.[17]

Generally, it appears that reasonably strong protections are in place to address the psychological mistreatment of children that results in, or which could result in, the child's permanent emotional injury or disability. Such provisions are helpful, not only for non-disabled children, but also for children with physical or sensorial disabilities who, because of the stresses and frustrations related to care-giving, may be at risk of emotional abuses that could cause psychological disabilities.

Psychological mistreatment that results in long-term emotional or psychiatric disability represents an extreme level of harm. Lesser but repeated harms, such as ongoing harshness and belittlement, over time can weaken the confidence and self-esteem of any child, regardless of disability. These harms are not clearly proscribed under provincial statutes. The only exceptions are found in prohibitions of verbal abuse in child care settings. Although these are critically important measures, children with disabilities are much less likely than other children to participate in child care settings (The Roeher Institute, 1993b). There does not seem to be a strong legislative framework to address the potential for verbal and emotional harm from providers of attendant support, respite services and other supports in the family home and in other settings.

Concerning adults with disabilities, legislation in a number of provinces and territories addresses emotional abuse. The *Adult Protection Act* in Prince Edward Island and Nova Scotia acknowledge the impact of emotional abuse for adults deemed "in need of protection". New Brunswick's *Family Services Act* applies to "neglected adults" and includes persons subjected to "mental cruelty" within its definition of abused adults. These provisions apply to adults who are elderly or who have disabilities, who are presumed unable to care for themselves or who refuse, delay or are unable to make provision for necessary care.

In British Columbia, licensed operators are prohibited from verbally or mentally abusing residents of "community care facilities".[18] Residents of the Northwest Territories and the Yukon who voluntarily place themselves, or who are involuntarily placed, in psychiatric facilities are similarly covered.[19]

Prince Edward Island is alone in defining the psychological abuse of adults with disabilities as acts that cause or are *reasonably likely to cause* severe physical or psychological

harm.[20] This provision may in effect narrow the scope of acts that might be considered abusive in that it would seem to require a severe level of psychological mistreatment.

Ontario affords adults who reside in nursing homes the right to courtesy and respect. This is consistent with the fundamental principle of the *Act* governing nursing homes, that these facilities are first and foremost the homes of the residents.[21]

Unlike some other provincial mental health legislation, Manitoba's expressly prohibits ill-treatment of people with mental disabilities and outlines penalties for offenders.[22] Similarly, Saskatchewan's provides for the preservation of rights of people receiving mental health services in the *Mentally Disordered Persons Act* (s. 14).

Quebec's *Charter of Human Rights and Freedoms* is broader in application, but less specific in terms of penalties and context in reference to protections against ill treatment. Section 4 stipulates that everyone "has a right to the safeguard of his dignity, honour and reputation".

As with physical harms, the most explicit provincial and territorial legal safeguards against the psychological abuse of adults with disabilities cover adults who are deemed neglected or in need of protection, or who reside in various care settings.

Abuse of Power Differential, Sexual Assault and Other Assaults

Federal Provisions

Federal law imposes sanctions against the abuse of authority and trust. For example, Bill C-15, passed into law in 1985, created several new offences relating to child sexual abuse and created new rules of evidence to facilitate the prosecution of such offences.[23] As a result of Bill C-15, section 150 of the

Criminal Code now establishes the general principle that the alleged consent of a complainant who is less than 14 years of age cannot be used as a defence by the accused. When the accused is younger than 16 and less than two years older than the complainant, consent can only be used as a defence where the accused is "neither in a position of trust or authority towards the complainant nor is a person with whom the complainant is in a relationship of dependency".

As if to underscore the odiousness of the abuse of authority, trust and social dependency, the *Act* specifies that, where a 12- or 13-year-old is accused of committing one of the offences under sections 151, 152 or 173(2), they cannot be brought to trial *unless* they are in a position of trust or authority towards the complainant or the complainant is in a position of dependency vis-à-vis the accused. Similar prohibitions of the abuse of authority and trust are embedded in section 153(1) of the *Code* regarding sexual touching and invitation to touching.

A limitation of these provisions is that they directly target sexual offences against children, applying only to individuals — with or without disabilities — who are chronologically younger than 14 years.[24] Moreover, provisions seem to work at cross purposes. On one hand, Bill C-15 draws attention to the abuse of power and trust and essentially prohibits such abuses for sexual purposes against children, regardless of the age of the accused. On the other, the *Criminal Code* sets out that coercive sexual touching or the invitation to sexual touching of children less than 14 years are offences punishable by a maximum prison sentence of 10 years.[25] However, it provides for a maximum of only five years when the accused is in a position of trust or authority in relation to the complainant or the complainant is dependent on the accused. One could argue that such relations between complainant and accused increase the seriousness of sexual offences, a point that is already

reflected in some aspects of the law. However, offences committed in the context of such relations are treated less seriously for the purposes of sentencing.[26]

Section 159(3)(b)(i) of the *Criminal Code* takes up the matter of the complainant's consent and provides safeguards that might be helpful for persons with disabilities who are reliant on others and at risk of those persons using force, threats, fear or obfuscation for sexual purposes. This subsection considers consent to anal intercourse to be lacking where "the consent is extorted by force, threats or fear of bodily harm or is obtained by false and fraudulent misrepresenting the nature and quality of the act". In such cases, the offence is punishable by a maximum prison sentence of 10 years.

Other provisions of the *Code* may be particularly relevant to individuals receiving care from persons who exercise authority or trust. Such persons would include staff in group homes, institutions and community agencies that provide intimate personal care services to persons with disabilities. Section 273.1 of the *Code* creates a general protection against sexual assault by presuming the lack of complainant consent where "the accused induces the complainant to engage in the activity by abusing a position of trust, power or authority" (s. 271.1(2)(c)).

The *Code* also imposes sanctions against other forms of assault by presuming lack of consent where persons exercising authority use force or threat of force against others (s. 265(3)(d)) or where intimidation or fraud are used to exact the complainant's submission.

Section 159(3)(b)(ii) of the *Criminal Code* takes matters one step further in establishing that consent is presumed lacking where "the court is satisfied beyond a reasonable doubt that the person could not have consented to the act by reason of mental disability". However, it might be argued that this

provision goes both too far and not far enough. It creates risk that the courts will take a paternalistic view and assume that, because an individual has a mental disability, they are *ipso facto* incapable of giving adult consent to anal intercourse. At the same time, the *Code*'s protection against sexual exploitation extends only to the act of anal intercourse and does not offer similar protections against other offences.

Section 273.1(2)(b) of the *Criminal Code* extends to sexual assault more generally by presuming the lack of consent where "the complainant is incapable of consenting to the activity". An argument could be made for limiting the interpretation of this provision to cases that involve the complainant's incapacity to give consent by reason of unconsciousness or intoxication.[27] However, the provision could be resorted to when the complainant has some form of "mental disability" that impairs his or her capacity to give informed consent. This could prove useful, for example, when an individual is exploited for sexual purposes while under the influence of strong medications for a psychiatric condition. Alternatively, the provision could also be interpreted paternalistically to mean that the presence of an intellectual or psychological disability automatically means lack of capacity to provide consent.

Provincial Law and Regulations

Although already covered under the *Criminal Code*, some provincial legislation explicitly prohibits various sexual offences against children and makes such offences grounds for child apprehension and protection.[28] As this report has already shown, provincial law also, in some circumstances, characterizes sexual abuse and other forms of assault as grounds for adult protection.

Involuntary Confinement and Treatment

Federal Provisions

The *Canadian Charter of Rights and Freedoms* guarantees the rights of everyone to "life, liberty and security of the person" (s. 7), "not to be arbitrarily detained or imprisoned" (s. 9) and the "right not to be subjected to any cruel and unusual treatment or punishment". However, the *Charter* applies only to state actions. A provincial court ruled that public institutions such as hospitals are not part of government for the purposes of the *Charter*.[29] Individuals living in other institutions, such as rehabilitation facilities, residential care facilities and group homes, may have difficulty resorting to *Charter* provisions if they have been involuntarily submitted by staff persons to actions that violate the arbitrary detention and other *Charter* provisions. However, section 279(2) of the *Criminal Code* creates an indictable offence for "every one who, without lawful authority, confines, imprisons or forcibly seizes another person". In a court of law, the onus falls on the defence to prove consent and to prove that the complainant's lack of resistance to the action was not the result of "threat, duress, force or exhibition of force".

It is possible that this provision could be relevant in situations where individuals are forced into social isolation for treatment or behaviour management or where the incapacitation of a mobility device (e.g., a wheelchair) for disciplinary purposes forcibly confines the individual who relies on the device. These kinds of actions could be construed as at variance with section 279(2) of the *Code*.

Provincial Law and Regulations

It might be argued that provincial law can theoretically extend authority to individuals to confine or otherwise restrict the liberty of persons with disabilities, which provides a legal defence for such actions. However, section 43 of the *Code* specifies that only school teachers, parents or persons standing in the place of parents are justified in using reasonable force as a correction. The Supreme Court has ruled that individuals such as counsellors do not stand in the place of parents or school teachers and therefore they cannot rely on this provision as a defence for using force. Moreover, the Supreme Court has held that it is not within the meaning of the provision to consider individuals such as adults with intellectual disabilities as children or pupils in relation to counsellors.[30]

Despite these considerations, provincial legislation is ambiguous concerning the right of people with disabilities to freedom from detention. Quebec's *Mental Patients Protection Act* provides for non-consensual detention and examination of adults, but only for those "showing signs of mental disorders likely to endanger the health or security of that person or the security of others".[31] Subsection 9(3) of Nova Scotia's *Adult Protection Act* provides for non-consensual provision of services, but only when it is clear that treatment is in the best interests of people covered under the *Act*. It should be noted that subsection 9(3) only authorizes the provision of services; it does not require the adult to accept them.

Alberta's *Dependent Adults Act* allows the person named as guardian or trustee to confine the dependent adult for the purposes of treatment for up to three years.[32] Ontario's *Mental Health Act* permits non-consensual procedures and psychosurgery. Section 1 authorizes the use of "necessary" physical force, mechanical means or chemicals to restrain patients to

prevent serious bodily harm to the patient or another person. The *Homes for the Aged and Rest Homes Act* in the same province permits the use of restraints where ordered and confirmed in writing by the physician to homes regulated under the *Act*. The nurse in charge, the administrator and the physician must draw up written policies concerning the use of restraints, subject to the approval of the minister. Similarly, Prince Edward Island's *Adult Protection Act* provides for non-consensual treatment when it is determined to be in the best interests of an adult covered under the *Act*, and it permits the use of restraints. In "emergencies", licensed operators of community care facilities in British Columbia are allowed to apply physical restraints under subsection 10(2) of the *Community Care Facility Act*. However, the same subsection forbids licensees to keep residents in a room and to lock them in a room.

Several provincial legal and regulatory provisions limit the lawful scope of service providers to physically detain, allow detention and socially isolate children.[33]

Offences Involving Money

Various sections of the federal *Criminal Code* prohibit money crimes, such as robbery (s. 343), that involve some level of actual or threatened physical violence.

At the provincial and territorial level, provisions have been enacted or are being contemplated to address the financial abuse of people with disabilities. Ontario's Bill 120 states that a written tenancy agreement must set out the charges for services and meals in care homes. Care services and meals will not be included in the rent and the rent for these premises will come under the jurisdiction of Ontario's *Rent Control Act*. In addition, the *Rent Control Act* stipulates that a landlord must give notice

before increasing the rates for meals or care. Ontario's *Developmental Services Act* also makes provision for the protection of people with intellectual disabilities from financial abuse.[34] Both legal provisions recognize the potential for financial abuse when someone's living arrangements are largely determined by their support needs. British Columbia's *Community Care Facility Act* attempts to protect residents from financial abuse at the hands of facility operators and employees.[35]

In contrast, the measures for the protection of adults from financial abuse in Prince Edward Island apply to all adults deemed "in need of protection", not merely to individuals in a given dwelling or receiving services. That means the legal protections of the *Adult Protection Act* accord status and protection principally to individuals as persons rather than to individuals as residents or consumers of services. The *Act*'s definition of abuse includes any offensive mistreatment of a physical, sexual, mental, emotional or material nature, or combination thereof, that causes, or is likely to cause, significant material loss to someone's estate. The disadvantage of legislation is that being placed under adult protection is a heavy price to pay for protection against financial abuses.

Quebec's legislation is even wider in scope. Section 48 of its *Charter of Human Rights and Freedoms* applies to all "aged and handicapped persons" and attempts to protect them "against any form of exploitation".

Privacy

Few provinces and no territories address the issue of privacy as it concerns persons with disabilities. Quebec has wide-reaching stipulations in its *Charter of Human Rights and Freedoms*, which enshrines the right of Quebec residents to

respect for their private life. Two provinces specify the protection of privacy with respect to persons residing in congregate care facilities. Under Prince Edward Island's *Community Care Facilities and Nursing Homes Act*, operators are bound to provide each resident with a reasonable opportunity for privacy and independence. Ontario's *Nursing Homes Act* confers upon all residents the right to privacy concerning treatment and care for personal needs.

Notes

1. The provisions and language vary somewhat across jurisdictions. In Ontario the limitation applies to persons who have been found mentally incompetent, patients in psychiatric facilities or persons incapable of giving evidence due to "unsoundness of mind". In the Yukon the term "mentally disordered person so found" is used instead of "mentally incompetent", whereas "lunatic" is used in Alberta. In the Northwest Territories a complainant's admission to a "hospital" (i.e., not specifically a psychiatric facility) due to mental disorder disqualifies uncorroborated testimony on the part of the complainant.
2. Sections 215–221 create a range of legal prohibitions against acts or omission that are not defined as homicide or murder but are, or may be, dangerous to life (i.e., criminal negligence).
3. General prohibitions of actions that endanger the life and health of children are provided for in section 218. Wanton or reckless disregard for the lives and safety of others are prohibited in section 219.

4. The prohibitions of assaults and sexual assaults, including assaults causing bodily harm, aggravated assaults and unlawfully causing bodily harm (sections 267–269; 272–273) use the same definition of bodily harm. Aggravated assaults involve more severe bodily harm, including the wounding, maiming, disfigurement or endangerment of the life of the complainant.

5. Apart from bodily harm and endangerment of life, the *Code* considers seriously compromised health to be a key litmus test of criminal failure to perform a duty. In some instances it would be difficult for the court to assess whether, or the extent to which, compromised health results from the individual's disability as distinguished from the failure of others to provide the support that the individual requires.

6. That is, it was not enough for the prosecution to show that the operators merely failed to perform their duties.

7. For example, Ontario's *Child and Family Services Act* authorizes the province to protect children who have a "mental, emotional or developmental condition" which, without remedy, would "seriously impair the child's development". The child's physical needs and the appropriate care and treatment to meet those needs must be considered by any person authorized to intervene and protect the child. Nova Scotia's *Children and Family Services Act* makes the same provision and uses similar language. See also Manitoba's *Child and Family Services Act*, Prince Edward Island's *Family and Child Services Act* and the *Family Services Act* of New Brunswick. See the following for legislation that provides general protection for all children, including children with disabilities, in the event of lack of access to medical and

other basic forms of care: the child welfare acts of Newfoundland, the Northwest Territories and Alberta, as well as the *Family and Child Service Act* of British Columbia.

8. For example, in Ontario the failure of parents or others in charge of a child to consent to necessary "treatment" to address disability is proscribed, whereas in Nova Scotia grounds for provincial intervention are parental and guardian failure to consent to "*services* or treatment". In Prince Edward Island, the neglect, refusal or inability of parents "to provide the *services and assistance* needed by the child because of the child's physical, mental or emotional handicap or disability" leave a wide margin for provincial child protection [Emphasis added.] In Manitoba, endangerment of the "life, health or emotional well-being of the child", including failure to obtain "medical or other remedial care or treatment for the health or well-being of the child" are large grounds for the province to intervene for the purpose of child protection.

9. See regulation 70 to Ontario's *Child and Family Services Act,* subsection 96; Prince Edward Island's *Child Care Facilities Act,* Part VI; Northwest Territories' *Child Day Care Act,* 26(1)(b); British Columbia's Child Care Regulation 319/89, s. 27(iv); the Northwest Territories' Child Day Care Standards Regulations, s. 26(1)(b); and Regulations 1990/115 and 1990/117 governing the Yukon's Child Care Centre Programs and Family Day Home Programs.

10. The same provision is in place for child care providers under Ontario's *Day Nurseries Act.* Prince Edward Island's *Child Care Facilities Act* imposes the same limitation on child care staff, as does Manitoba's

Community Child Day Care Standards Act, Saskatchewan's *Child Care Act*, British Columbia's Child Care Regulation 319/89, the Child Day Care Standards Regulations pursuant to section 38 of the Northwest Territories' *Child Day Care Act* and regulations governing the Yukon's Child Care Centre Programs and Family Day Home Programs.

11. Newfoundland's *Neglected Adults Welfare Act* recognizes as a "neglected adult" individuals with a disability (i.e., "physical or mental infirmity") who, because of their condition, are unable to care for themselves and who are not receiving proper care and attention. Section 11 provides that persons whose acts or omissions result in, or contribute to, the neglect of such individuals are liable to fines and imprisonment. New Brunswick also includes within its definition of neglected adults persons with disabilities and elderly persons who have been, or who are, at risk of physical abuse. The minister may apply for a court order to remove any person believed to be contributing to, or causing, the neglect or abuse of such adults.

Section 1(a) of Prince Edward Island's *Adult Protection Act* includes within its definition of abuse offensive physical mistreatment "that causes or is reasonably likely to cause the victim severe physical or psychological harm or significant material loss to his estate". Such adults may be found "in need of protection" when, among other reasons, they are unable because of disability or other incapacity to remedy the situation and are ongoing victims of abuse, neglect or endangerment by "someone having recognized supervisory responsibility for the person's well-being". Here, the legislation requires an ongoing pattern of harm.

The physical abuse of an adult with disabilities "in the premises where he resides" and who, for various reasons, fails to protect himself, is proscribed under Nova Scotia's *Adult Protection Act*. Such adults may be found in need of protection. The access of third parties to such a person may be restricted if they are deemed by a court to be a source of danger to the neglected adult. New Brunswick's provisions in Part III, section 34(2), of its *Family Services Act* identifies an abused adult as one who is elderly or who has a disability, who fails for various reasons to make provision for their own care or attention, and who is a victim, or at risk of being a victim, of physical or sexual abuse.

12. The Patient Advocate Regulation 310/89 of Alberta's *Mental Health Act* governs the procedure for investigating and preparing reports in response to patient complaints. Pursuant to section 8 of Alberta's *Social Care Facilities Review Committee Act*, the committee shall investigate all complaints made by, or on behalf of, someone in a facility. These facilities, as defined by subsection 1(f)(i) of the *Social Care Facilities Review Committee Act*, are places of care for persons who are aged, infirm or who require special treatment.

Section 4 of Newfoundland's *Neglected Adults Welfare Act* requires mandatory reporting of suspected neglected adults to the director responsible for overseeing the *Act*, whereas in Prince Edward Island, reporting is not mandatory according to section 4 of the *Adult Protection Act*. Section 5 of Newfoundland's legislation and sections 4 and 5 of Prince Edward Island's *Act* provide for investigation of the conditions and status of adults alleged to be neglected. Section 7 of the *Act* passed

in Prince Edward Island mandates cooperation of adults with a disability and all others concerned with their well-being in investigating complaints and provides for court-ordered assessment in the event of non-cooperation.

Pursuant to section 5(r) of Ontario's *Homes for the Aged and Rest Homes Act*, the duties of home administrators include establishing and following a regular procedure for hearing grievances. The same section requires operators to maintain a written record of all such hearings and to take corrective steps as they deem necessary.

Prince Edward Island's *Community Care Facilities and Nursing Homes Act* requires operators to provide residents with the opportunity to express any concerns about the operation of a facility and to become involved in any decisions that might directly affect them.

13. Bill 120, which at the time of writing had passed third reading and is about to be proclaimed into law, will bring care homes under the *Landlord Tenant Act*. Subsection 1(2) defines care homes as residential premises occupied by a person for the purpose of receiving care services, whether or not receiving the services is the primary purpose of occupancy. Subsection 1(1) indicates that "care services" include health care services, rehabilitative or therapeutic services, or services that provide assistance with the activities of daily living. The Bill stipulates that a written tenancy agreement must be entered into whenever a care home is leased. Furthermore, municipal approval will have to precede demolition, conversion, renovation or repair of care homes in Ontario. Bill 120 is largely the result of recommendations arising from *A Community of Interests: The Report of the Commission of Inquiry into Unregulated Residential Accommodation* (1992).

14. Forced medical treatment might in some instances be construed as state action arising from discrimination against persons with disabilities in which the doctor acts as an agent of the state.

15. Provincial intervention for the purposes of child protection can be triggered where mistreatment by a parent or someone in charge of the child causes serious psychological problems for the child. For example, Manitoba's *Child and Family Services Act* includes as a form of abuse any act or omission that results in "emotional disability of a permanent nature in the child or that is likely to result in such a disability". Saskatchewan makes similar provision in its *Child and Family Services Act* (s. 81(1)(b)). Subsection 1(3) of Alberta's *Child Welfare Act* makes emotional injury of a child grounds for child protection. The Northwest Territories' *Child Welfare Act* considers a child in need of protection where "the child is deprived of affection ... to the degree that, on the evidence of a psychiatrist, is sufficient to endanger the emotional and mental development of the child". It defines abuse as including "mental ill-health of a degree if not immediately remedied could seriously impair growth and development or result in permanent injury or death".

16. For example, Prince Edward Island's *Family and Child Services Act* explicitly includes children with disabilities within the ambit of the act and accords them, like other children, protection from "any mental, emotional or sexual mistreatment". In Saskatchewan, the definition of child abuse under the *Child and Family Services Act* includes child exploitation and cruel treatment. Manitoba's *Child and Family Services Act* (s. 17(1))

considers any child to be in need of protection whose "emotional well-being ... is endangered".

17. For instance, Regulation 70 to Ontario's *Child and Family Services Act* (s. 96(a)) prohibits licensees of child care facilities from using, or permitting the use of, "deliberate harsh or degrading measures to humiliate a resident or undermine a resident's self-respect". Regulation 262 to the *Day Nurseries Act* (s. 45(a)) makes a similar provision. Supervisors in Prince Edward Island's child care facilities are required to prohibit any form of verbal or emotional abuse under the *Child Care Facilities Act* (Part VI). Manitoba's *Community Child Day Care Standards Act* expressly forbids "verbal or emotional abuse upon ... any child in attendance at the day care centre". Saskatchewan makes similar provision in its *Child Care Act* (s. 13(1)(b)), as does the Northwest Territories in its *Child Day Care Act* and the Yukon in its regulations governing Child Care Centre Programs and Family Day Home Programs. British Columbia prohibits child care providers from engaging in "harsh, belittling or degrading treatment, whether verbal, emotional or physical, that would humiliate the child or undermine the child's self-respect" in Child Care Regulation 319/89 (s. 27).

18. This provision is contained in the Adult Care Regulation 536/90 passed pursuant to the *Community Care Facility Act*. According to section 1 of the *Act*, "community care facilities" include any facility that provides care, supervision, training or rehabilitative therapy, with or without charge, to three or more persons not related to the operator.

19. Subsection 40(1) of the Northwest Territories' *Mental Health Act* defines abuse as "any act that physically,

mentally or emotionally injures, causes undue discomfort or fear or takes unfair advantage of a patient". Subsection 40(4) of the Yukon's *Mental Health Act* states, "A patient has the right to security of the person and, except as otherwise authorized under this Act, no person shall subject a patient to any act that physically, mentally or emotionally injures the patient, or causes the patient undue discomfort or fear or takes unfair advantage of a patient at any time during observation, examination, care or treatment."

20. Subsection 1(a) of the *Adult Protection Act*. Material loss is also listed as a form of abuse, an issue that is discussed in more detail below.

21. Subsection 2(2) of Ontario's *Nursing Homes Act* specifies, "Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse."

22. Manitoba's *Mental Health Act* (s. 103) says that anyone who ill-treats or wilfully neglects a "mentally disordered" person and who has charge, care, control or supervision of that person, through contract, tie of relationship including marriage or otherwise, is guilty of an offence. Section 105 says anyone who violates any provision of the *Act* is liable to a fine of up to $500 and/or imprisonment of up to one year.

23. These new offences are: sexual interference (s. 151), invitation to sexual touching (s. 152), sexual exploitation (s. 153) and exposure (s. 173(2)).

24. Case law has established the principle that the complainant's purported "mental age" of less than 14

years cannot be used to invoke the provisions of the *Act*. The inability to give consent is presumed only for complainants who fall within the chronological or biological age parameters.

25. See sections 151 and 152.

26. Another potential problem of Bill C-15 is that the provision limiting the use of evidence about the complainant's alleged consent as a basis for defence purposes may be found at variance with sections 7 and 15 of the *Charter*.

27. Intoxication was originally specified as the cause of temporary incapacity to give consent.

28. The *Criminal Code* (s. 171) also provides for the criminal liability of "every owner, occupier or manager of premises or other person who has control ... or assists in the management or control of premises" who permit certain sexual activities involving persons younger than 18 years. "Owner" is defined broadly to include the Crown, a range of public and private bodies and individuals. It is conceivable that an institution, society responsible for a group home, or individual staff person could be charged under this section of the *Code* when they fail to take steps to prevent such activities involving young persons with disabilities.

29. See *Stoffman v. Vancouver General Hospital,* 1990. It may be the case, however, that individuals with disabilities who are found to be in need of state protection and who are placed in institutional care could resort to the *Charter* where it could be shown that the state failed to prevent the institution from infringing the individual's rights and freedoms.

30. See *R. v. Nixon,* 1984, and *R. v. Ogg-Moss,* 1984.

31. Pursuant to section 10 of the *Act,* a report must be made to the Public Curator. *The Civil Code of Lower Canada* specifies the powers of the Public Curator, which include the ability to intervene in any proceedings pertaining to "protective supervision" of adults.

32. A dependent adult, for the purposes of the *Act,* is anyone under a guardianship order, a trusteeship order or both.

33. See Ontario's *Child and Family Services Act* (Part V, s. 100) and Regulation 70; Regulation 1 to Saskatchewan's *Child Care Act* (s. 13(1)(d)); and British Columbia's Child Care Regulation 319/89 (s. 27(iii)).

34. Those who reside in facilities designated for people with an intellectual disability are subject to section 25: "Every gift, grant, alienation, conveyance or transfer of property made by a person who is or becomes a resident shall be deemed to be fraudulent and void as against the Public Trustee if the same was not made for full and valuable consideration actually paid or sufficiently secured to such person or if the purchaser or the transferee had notice of her mental incompetence."

35. Subsection 12(e) stipulates that neither licensees nor employees of community care facilities shall "persuade or induce, or attempt to persuade or induce, a resident to make or alter his will, or to make a gift, to provide a benefit for the employee or spouse or relative of either of them under the will or by gift, or influence the resident for the benefit of the operator or employee, or relative of either of them".

Chapter 7. Case Law

Various principles and safeguards have evolved through the legislative and judicial process that protect the survivor's right to provide testimony, which ideally would be judged in court on its own merits. These safeguards are not evenly applied, however. Many cases are dismissed out of concern for the credibility of the complainant's or plaintiff's testimony. Other cases never make it to court.

Nevertheless, a body of emerging case law is showing that the courts have grounds for seriously considering the stories of persons with disabilities, even those whose testimony presents challenges. Criminal convictions have been rendered in several of these cases. Some sentencing decisions point to society's revulsion concerning abuse and violence against persons with disabilities. In other cases, however, court rulings have left murky impressions concerning violence and abuse against persons with disabilities. For example, in child custody cases the courts have ruled in *the best interests of the child*. In some cases this has meant awarding custody to the parent least likely to abuse the child and most likely to care for the child's needs. In other cases, the courts have created the impression that it might be more acceptable for parents to use strong physical force against children with disabilities than against those without disabilities.

Concerning cases of abuse and violence against adults with disabilities residing in various care settings, the courts have typically not ruled in favour of the complainant. Few cases have been tried concerning verbal and emotional abuses. Courts have also ruled that, although *Charter* rights to freedom and security of the person must in principle be upheld for persons

with disabilities, it is permissible for individuals operating under the authority of provincial mental health legislation to infringe those rights and freedoms when they can create a solid defence for doing so.

The following discussion explores these and other issues in greater detail by looking at select cases in federal and provincial jurisprudence concerning violence and abuse against persons with disabilities.

Provision of Evidence and Credibility of Testimony

The Supreme Court of Canada has ruled that common sense rather than rigid stereotypes should guide the courts in their assessment of the credibility and evidence of witnesses with disabilities. The Supreme Court has held that:

> Every person giving testimony in court, of whatever age, is an individual, whose credibility and evidence must be assessed by reference to criteria appropriate to her mental development, understanding and ability to communicate. (*R. v. W.(R.)*, 1992)

Concerning the admissibility of medical or psychiatric evidence to impeach the testimony of a witness with a disability, an Ontario court has ruled that it is not enough to show that a witness simply has a psychiatric disturbance. Instead, the evidence must show that the condition affects the witness's capacity to provide credible testimony.[1] More recently, a Nova Scotia court refused to allow the evidence that the defence sought to introduce concerning a complainant's multiple personality disorder. It was the court's position that such evidence would not have shed light on the reliability of the complainant's testimony. The court stated:

> There was nothing in Dr. Allison's report which would indicate that the appellant's complicated medical condition, however unfortunate, was such as to make her evidence about a sexual assault made upon her unreliable. A mentally handicapped person is clearly more vulnerable to being victimized than others. The mere fact that such a victim, particularly of sexual assault, has a psychiatric history is not of itself relevant. (*R. v. Nickerson,* 1993, p. 20)

Although case law has established that a witness's disability is not in itself a basis for doubting the person's testimony, other rulings leave in question the point at which a witness's disability becomes relevant to the issue. For example, the Quebec Court of Appeal found that evidence of a witness's "hysteria" and tendency to fabricate went against the witness's credibility. The court ruled that, since the jury would not necessarily recognize or understand the implications of the disorder, psychiatric evidence about the witness's condition was necessary in assessing credibility (*R. v. Julien,* 1980). In *Ruiter v. Ruiter* (1986), a Saskatchewan court simply refused to hear the testimony of an 11-year-old child, in part because the child had a learning disability. In *R. v. Chin* (1987), the British Columbia Court of Appeal granted appeal in a case where the testimony of the complainant was ultimately discounted as of little assistance because of her purported suggestibility and because the credibility of her testimony hinged on the evidence of another witness.[2] On appeal was the complainant's allegation of sexual assault by a medical doctor.[3]

In *R. v. Gadway* (1993), the *lack* of professional evidence concerning the impact of disability on a complainant's testimony led the Yukon Territorial Court to dismiss the case. A woman with an intellectual disability alleged, in this case, that she had been sexually assaulted on three separate occasions by the accused. Concerning the testimony of the complainant

and her roommate, who also had an intellectual disability, the court found, "In the absence of any medical or expert evidence, the impact of their mental handicap on their ability to testify is primarily open to dangerous speculation" (p. 38). Although the court had the clear impression that the complainant and roommate were telling the truth, the court felt that the truth of their allegations could not be established beyond a reasonable doubt. The court expressed, with some frustration, that:

> The tragedy of their vulnerability is heightened by their limited access to protection from the justice system. Mentally disabled victims do not fare well in our verbally based adversarial system that demands mental agility, a good memory, quick responses, and a facility to readily employ a rich vocabulary to accurately describe or slyly obfuscate truth. It is possible, and must be made possible, for a mentally handicapped person to provide reliable, credible testimony. (*R. v. Gadway,* 1993, p. 49)

The Gadway case points to the difficulty that some complainants with disabilities have in the courts, despite the presence of corroborating evidence.[4] In *R. v. Gadway,* the evidence of both the complainant and her roommate were found to be problematic on several grounds. This was also found to be the case concerning the corroborated testimony of the complainant in *R. v. Chin.* In both cases, the courts indicated that they had reason to believe the complainants. Ultimately, however, in neither case did the court actually find for the complainants.

Whether the evidence of survivors with disabilities is accepted depends in part on who corroborates it and their perceived credibility as witnesses. Social workers and medical personnel are typically seen as having greater credibility than witnesses with disabilities. For example, in *Children's Aid Society of Stormont v. W.W.* (1987), the Ontario Provincial Court accepted the evidence of a social worker concerning the

sexual abuse of a 10-year-old girl with significant intellectual and communication disabilities. The hearsay evidence provided by social workers, neighbours and medical staff was largely responsible for a ruling in Newfoundland that two children, one of whom had a severe intellectual disability, were in need of protection (*Director of Child Welfare (Newfoundland) v. J.M. and G.M.*, 1990).[5]

However, not all cases involving inconsistent testimony on the part of complainants with disabilities meet with scepticism in the courts. For example, the Northwest Territories Supreme Court allowed the unsworn testimony of a female complainant with an intellectual disability who alleged that her father sexually assaulted her when she was 13 years old (*R. v. K.H.*, 1992). Although the complainant was suggestible and gave inconsistent statements, the court held that these testimonial problems were incidental to the assault. The court convicted on her evidence. In a case of assault, the same court also accepted evidence, despite inconsistencies, given by a complainant with an intellectual disability (*R. v. Harrison*, 1988).

The rules of evidence may not be as much of a problem in the regulation of institutional care facilities by provincial review boards. This is because provincial review boards are not required to adhere to the same strict rules of evidence as the courts. An example is a British Columbia case in which a provincial review board suspended the licence of a day care centre because of allegations of child abuse. In *Wilkins v. Provincial Child Care Facilities Licensing Board (British Columbia)* (1986), the B.C. Supreme Court found that, providing the board operated within its mandate, its reliance on uncorroborated and hearsay evidence was procedurally acceptable for the purpose of licence suspension.

Abuse and Assault

Particular considerations arise in cases that involve the abuse of children with disabilities. In *Children's Aid Society of Stormont v. W.W.* (1987), the Ontario Provincial Court recognized that the child, who had significant intellectual and communication disabilities, was at greater than usual risk of sexual abuse because she would be unable to disclose any incidents of inappropriate behaviour towards herself. On the basis of the child's use of anatomically correct dolls to demonstrate to a social worker that she had sexual knowledge inappropriate for her age, permanent guardianship was awarded to the Society.

In *Superintendent of Family and Child Services v. M.(B.) and O.(D.)* (1982), an appeal court found that a child can be abused during the gestation period and that a drug-addicted child such as the one in question was indeed born abused. The court also found that, although not yet subjected to actual mistreatment, a child may be deemed in need of protection on the basis of anticipated deprivation and on the basis that the child's behaviour will in all probability exasperate its parents, potentially leading to its abuse and injury.[6]

In the child custody dispute of *Austin v. Austin* (1987), the court accepted evidence that the developmental lags of the two children resulted from the bizarre behaviour of the children's mother. Custody was awarded to the husband.

It is not altogether clear at what point the corporal punishment of children with disabilities is considered abusive under provincial case law. The *Criminal Code* (s. 43) allows for the use of reasonable force by a parent for the purposes of correction. In *Director of Child Welfare (Newfoundland) v. J.M and G.M.* (1990), it was found that the parent had crossed this boundary. The case involved two children, one of whom had

significant intellectual and communication disabilities. It was stated that in light of the child's disabilities "the court must exercise even more caution than would normally be the case to ensure protection of that child". The court expressed sympathy for the child-rearing difficulties faced by the parent, but also ruled, "There is no justification ... for the type and extent of corporal punishment that has been described to me, to be employed on any child and particularly on one as disabled as this one". The children were declared in need of protection and were sent home under permanent provincial supervision.

However, the British Columbia Provincial Court recently ruled that physical discipline is not *per se* physical abuse and suggested that in some circumstances corporal punishment may be *more* warranted or understandable when the child has a disability. In this case, the British Columbia Superintendent of Child and Family Services sought permanent guardianship of a child with severe intellectual and physical disabilities who was allegedly abused by his parents. In refusing the application, the court said:

> T. isn't a normal child. Many of the manifestations of his condition are peculiarly aggravating — the tantrums, the constant repetitions — and besides that he can be naughty ... So it seems ... he has a high capacity to try a care-giver's patience. Also, to one of such limited understanding as T., a smack is an unmistakable signal, whereas some of the alternatives suggested are more ambiguous ... I don't accept that physical violence is so obviously wrong in T.'s case. (*Re T.L.D,* 1991)

Much of the case law concerning the abuse of adults with disabilities relates to residents of institutions. For example, the Ontario District Court found an untrained operator of a residential care facility for persons with schizophrenia, paranoia and personality disorders guilty on many counts of physically abusive conduct towards the residents (*R. v. Thibeault,* 1989).

In this case, however, the convictions tended to pertain to allegations that were corroborated by the evidence of staff persons. The testimony of the survivors was not accepted at face value.

In a Nova Scotia case, evidence that an institutionalized adult was receiving adequate medical and nursing care and was not subject to physical, sexual or mental abuse was a basis for the court to refuse an adult protection order to the Minister of Social Services (*Nova Scotia (Minister of Community Services) v. R.A.M.*, 1992). In this case the court reasoned that such an order would have served no practical purpose and would have offended the individual's dignity.

A number of civil cases involving allegations of harm committed by professionals and institutions have come before the courts. In many of these cases, the courts have not found in favour of plaintiffs with disabilities. For example, in *Nemeth v. Clark Institute* (1988), the Supreme Court of Ontario dismissed actions on the basis that the plaintiff had failed to establish negligence or lack of consent. The plaintiff had accused the Clark Institute of failing to provide a reasonable standard of care for his safety, which allegedly resulted in an assault by another institutional patient. The plaintiff also alleged negligence in that the Institute provided improper diagnosis and medication and committed assault and battery through the administration of non-consensual electro-convulsive shock therapy.

In *Misir v. Children's Rehabilitation Centre of Essex* (1989), the Ontario District Court found that the standard of care in the institution was that of a careful and prudent parent and that the teachers had met that standard. Action against the centre and the teachers was therefore dismissed. In this case, the plaintiff was a student with muscular dystrophy and a wheelchair user at the centre. He was attacked by another student, who broke his arm. The allegation was that the centre

and staff had failed to provide proper care by leaving the children unsupervised prior to class.[7]

McConnell v. Lemke (1992) involved an allegation against a physician employed by a residential care centre, the Director of Rehabilitation and the Minister of Social Services and Housing of failure to exercise reasonable care in preventing an assault. The plaintiff claimed that she was punched in the face by another resident of the facility. The B.C. Supreme Court dismissed the action on the grounds that the facility was specifically for individuals with behavioural problems and was non-custodial. The court felt that the plaintiff could have left the facility if truly frightened but failed to do so.

In *Kohn v. Globerman and Shane* (1986), the plaintiff accused two psychiatrists of negligence, assault, defamation, conspiracy and false imprisonment. However, the defendants successfully showed that there were no reasonable grounds for alleging lack of good faith or reasonable care and that the *Mental Health Act* granted them protection against civil liability for actions done under the authority of the *Act*.[8]

Although much of the civil case law concerning the assault and abuse of adults with disabilities pertains to institutional residents, the courts have also ruled in cases involving parental abuse and failure to meet the needs of adult offspring with disabilities.[9]

Failure to Meet Essential Needs

There is case law that establishes that disability-related needs are tantamount to basic needs that must be met. In *Children's Aid Society of the Regional Municipality of Waterloo v. T.R.* (1990), the social service ministry expressed concerns about the alleged inadequacy of physical care, structure, routine, behaviour controls and medical care being provided by a

consensual guardian to a 16-year-old male with an intellectual disability.[10] The Ontario Provincial Court indicated that every child has the right to have his or her "special needs" addressed on a long-term and consistent basis.

In child custody and visitation disputes between parents, the courts have ruled in favour of the parent least likely to abuse the child and most able to respond to the child's disability-related needs.[11]

Case law tends to reinforce the notion that the primary responsibility for meeting the disability-related and other needs of persons with disabilities rests, in lieu of the individual, with the family. For example, in *Re J.S.D.* (1989), concerns were raised about the mother's excessive corporal punishment of her twin five-year-old boys with "special needs". The Alberta Provincial Court decided that protective services were required but that the children's security, survival and development could be protected within the context of the family.[12] Similarly, against the claims of the Minister of Social Service, the Nova Scotia Family Court awarded the husband and son with custody and responsibility to care for an aged woman with senile dementia who had previously been found in need of protection.

Case law also reinforces the notion that the family has primary responsibility to provide for the *special needs* of people with disabilities and in that sense has a responsibility to shield them from neglect and deprivation. Nevertheless, a sense of the state's ultimate obligation in this area seems to have guided the judgements in several cases involving child apprehension. In *P.E.I. v. Henderson* (1986), a child with neurological developmental problems was placed under guardianship on the basis that the mother could not meet the child's needs.[13] In *Winnipeg South Child and Family Service Agency v. H.(L.C.)* (1987), the court found that the needs of a child who had both

physical and intellectual disabilities would require major commitment from many people, including her primary care-givers. The court found that the parents were unable or unwilling to make the required commitment and awarded custody to the Children's Aid Society.[14] The Nova Scotia Family Court found in favour of the Minister of Community Services in a case where the mother was deemed unlikely to provide for the socialization, communication, living and adaptive behaviour skills of her 45-year-old son with a significant intellectual disability (*Nova Scotia (Minister of Community Services) v. B.(L.)*, 1991).

Concerning the role of the state in relation to the neglect and deprivation of adults, a Nova Scotia court recently recognized as "a fundamental principle of our society that the state has an obligation to care for disabled or incompetent persons who are unable to care for themselves". However, the court also identified the boundaries that the *Charter* sets to the state's intervention in this regard, referring to the need for legal safeguards and procedures "to ensure that the adult's rights to privacy and independent living are not violated" (*Nova Scotia (Minister of Community Services) v. L.K.(Keeble)*, 1991). That is, the court upheld the notion that the state has an obligation to address basic and disability-related needs, but not in a manner that persons with disabilities are likely to experience as controlling, invasive of privacy or restrictive of individual liberties. The state was also implicitly recognized as the ultimate care provider of an adult patient in *Moase v. Prince County Hospital* (1979). In this case, the plaintiff accused the doctor of assault, battery and false imprisonment. The Newfoundland court dismissed the action against the hospital on the basis that alleged misconduct of the staff must be taken against the province, as represented by the Minister of Health.[15]

Denial of Liberty and Security

The research interviews revealed that persons with disabilities depicted situations and actions as violent and abusive in which they were controlled by others and denied ordinary freedoms. Case law has addressed several instances in which the liberties of persons with disabilities have been infringed or contested. To some extent, these overlap with cases in which there is a lack of consent to treatment (see below).[16] At issue in the case of *Re C.P.L.* (1988) was the apprehension by Newfoundland's Director of Child Welfare of a child with numerous medical problems who required surgery. For religious reasons, the parents refused to have the surgery performed. The court found that various provisions of the former *Child Welfare Act* contravened the child's rights to liberty and security under section 7 of the *Charter*. The court considered the child's apprehension equivalent with arrest and deprivation of liberty, and the surgery, a deprivation of security. The court ruled that these rights could only be taken away in accordance with the principles of fundamental justice, which included the child's right to be informed through his parents and his parents' right to retain counsel and have the validity of the detention determined in a judicial hearing.[17]

Nova Scotia's *Adult Protection Act* fell under scrutiny for similar reasons in *Nova Scotia (Minister of Community Services) v. L.K.(Keeble)* (1991). Here, the husband and son of an aged woman with senile dementia were awarded custody to provide her with care. The Nova Scotia Family Court ruled that, under *Charter* provisions that ensure liberty and security of the person, the minister had no authority to detain an adult in need of protection who refuses services, except in accordance with the principles of fundamental justice.

The courts have required that procedural safeguards be followed in cases where individual liberties are at issue. In *Re Kemp* (1991), two daughters sought to be appointed personal and property guardians under Saskatchewan's *Dependent Adults Act* (c. D.25.1). Basing its ruling on the case of *Re Cochran* (1964), the court warned that great caution and substantial proof are required before interfering with a person's estate or liberty. The court held that depriving the individual of liberty, independence and control was such a serious matter that medical reports in affidavit form attesting to the woman's dependency had to be provided before any judgement could be reached.

However, the courts have tended not to uphold allegations of improper confinement when professionals commit individuals with psychiatric disabilities involuntarily to mental health facilities and where it can be shown that those professionals are operating responsibly and in good faith under the provisions of mental health legislation.[18] The rationale has been that *Charter* provisions concerning liberty and security do not outweigh other statutes authorizing the state to infringe liberties in the interests of protecting individuals from harming self or others. However, where harm to self or others or its imminent likelihood has not been established, the courts have come to a different ruling. In *Nova Scotia (Minister of Community Services) v. Perry* (1990), the court ruled that the individual's right to security of the person and her right to freedom from unreasonable detention took precedence over the authority of the state to provide non-consensual protective and treatment services. In this case, the court found that the likelihood of the adult becoming a danger to self or others was only prospective. Subsection 9(3) of the *Adult Protection Act* was therefore found to be outweighed by sections 7 and 9 of the *Charter*.

In *Tanner v. Norys* (1979), where the professional conduct of mental health professionals was clearly in question and where the liberty of the plaintiff was infringed, the court ruled in favour of the plaintiff. In this case, an action of false arrest and false imprisonment was successfully brought against a psychiatrist who allegedly breached the involuntary treatment and committal provisions of Alberta's *Mental Health Act*. It was found that the defendant failed to examine the plaintiff on the date of apprehension and failed to consider carefully whether the plaintiff's rational and behavioural states were consistent with "mental disorder". The defendant also failed to provide careful professional judgement as to the plaintiff's danger to self and others.

In *Moase v. Prince County Hospital* (1979), where the alleged inappropriateness of professional conduct was not so clear, the Supreme Court of Prince Edward Island allowed the matter to go to trial. The defendant, a doctor, moved for dismissal, arguing that the plaintiff failed to comply with a provision of the *Mental Health Act* that required the approval of the Minister of Justice before an action against a staff person of a psychiatric facility could commence. The court ruled that this provision would only apply if the doctor could be shown to have acted within his authority under the *Act*, a matter that could only be determined at trial.

Lack of Consent

Consent to Care and Treatment

The research interviews found that the absence of consent was a key factor in many of the situations and actions that respondents portrayed as violent or abusive. Treatments and care to which individuals do not consent were reported as

specific ways in which violence and abuse are manifested in the lives of persons with disabilities.

A number of cases that involve the involuntary care and treatment of persons with disabilities have come before the courts. In these cases, the courts have addressed the issue of individual rights and freedoms. In cases where other persons seek or exercise guardianship powers to consent to treatment on behalf of an individual, the court has sought proof that the individual's condition warrants guardianship. For example, the Prince Edward Island Supreme Court required that an assessment be performed before it would appoint a guardian for the purposes of consenting to medical treatment in *Re Gardiner* (1992). Similarly, in *Re Johannasen* (1984), an Alberta court found that the Public Guardian's application for a compulsory care order was a grave matter in that it involved the personal liberty of the individual. Proof of the individual's alleged need for compulsory care therefore required "a degree of probability which is commensurate with the occasion". The person had a mild level of intellectual disability and epilepsy that was controlled by medication. The court found that the individual was not in a "condition that presents a danger to himself and others" as required by s. 10.1(3) of Alberta's *Dependent Adults Act*. Accordingly, the court dismissed the guardian's application. In other cases, such as *Re Henry Osinchuk* (1983), an Alberta court has made clear the limited nature of the guardian's mandate with respect to substitute consent to medical treatment.[19]

The issue of exactly where the responsibility is vested to authorize compulsory treatment was addressed in *Re M.R.* (1991). In this case, the Prince Edward Island Supreme Court held that the committee that had custody of the person has no such jurisdiction. Instead, the court ruled that such treatment must be authorized by the court, under its *parens patriae* jurisdiction.

Similarly, the court acted pursuant to its *parens patriae* jurisdiction and provided a substitute consent to psychiatric treatment in the case of *Institut Philippe Pinel de Montréal v. Dion* (1983). Following an examination of psychiatric evidence and a consideration of individual rights, the Quebec court found that the respondent could manage his own affairs and in fact was of "superior intelligence". However, because he denied that he had a severe mental illness, the court found that the respondent was capable neither of appreciating his need for treatment nor of recognizing that his situation was likely to deteriorate seriously if he did not receive it. The court therefore found the respondent incapable of providing valid consent to the psychiatric treatment that the court deemed to be necessary.

The Dion case involved more than issues concerning individual liberties and treatment. As in the case of *Re M.R.* (1991), the court was concerned that its role in providing substitute consent to treatment not be usurped by the psychiatric institution. Underscoring the point, the judge read an excerpt from a ruling by the Supreme Judicial Court of Massachusetts, in which it was stated that questions of life and death require the "detached but passionate investigation" that forms the ideal of the judiciary:

> Achieving this ideal is our responsibility and that of the lower court, and it is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted. (*Institut Philippe Pinel de Montréal v. Dion*, 1983, p. 242)

Consent to Sexual Activity

The research interviews found a disturbing prevalence of sexual assaults against the persons who were interviewed. In cases of alleged sexual abuse or assault where the complainant has a

communication, intellectual or psychiatric disability that renders his or her testimony inconsistent or open to doubt on other grounds, it can be difficult for the Crown to establish in court the lack of victim consent to sexual activities experienced as violent or abusive.[20]

Arguments based on the mental, as opposed to the chronological, age of alleged victims have not clarified matters greatly. For example, in *R. v. Duguay* (1990), sentence and conviction were appealed on three counts of sexual assault and one count of anal intercourse involving a 14-year-old girl. One judge in the Court of Appeal held that the trial judge was correct in accepting the evidence of the girl's mother and teacher to the effect that the girl was mentally younger than her biological age. The Appeal Court judge also held that the trial judge's ruling was correct that, because of her mental age, the girl could not have assented to the alleged activities.[21] However, a dissenting Appeal Court judge felt that the girl's purported mental age was irrelevant because the *Criminal Code* simply stipulates that the biological age of 14 is the threshold below which adult consent is not available. Instead, the judge argued, the Crown should have produced and failed to produce compelling evidence to the effect that the girl's mental or psychological disability was such that she could not have assented to the activities. Moreover, the dissenting judge found that the Crown failed to show that the accused was clearly aware of the complainant's mental state and exploited it for sexual purposes.

Despite difficulties in demonstrating lack of consent to sexual activities and assaults, several cases have made it through "the system". These cases are discussed below in terms of sentencing provisions.

Penalties and Other Sanctions

Sentences

Sentences for violence against individuals with disabilities reflect whether the courts view such incidents as serious matters. Generally speaking, sentences — if not initially, at least on appeal — do tend to reflect the view of the courts that victimizing an individual with a disability is a particularly serious offence. Disability is often considered to be an aggravating factor during sentencing.

In the recent and highly controversial case of *R. v. Latimer* (1994), the defendant was accused of, and admitted to, ending the life of his daughter who had severe and multiple disabilities and who was perceived to be in constant pain. The defence argued that the defendant's motives for the killing were compassionate. Nonetheless, the court found the defendant guilty of first degree murder. He was sentenced to life in prison without parole for 10 years.[22]

A sentence of 12 months' imprisonment, two years' probation and counselling for substance addiction was imposed in a case involving the bodily harm of an individual with a perceptible physical disability (*R. v. Drury*, 1989). In imposing this relatively strong sentence, the court looked at other cases of assault where crime victims were rendered helpless or more vulnerable by external circumstances, such as a broken leg or prostrate position during an assault. The court essentially upheld sentence in *R. v. Brucker* (1986) on the ground that the victims of aggravated assault and robbery were either of advanced years or had significant physical disabilities.[23]

The Prince Edward Island Supreme Court Appeal Division also upheld the sentence of an appellant who was convicted of robbing an individual with poor eyesight and below average

intelligence (*R. v. Chaisson*, 1990). The sentence was nine months' imprisonment, two years' probation, treatment for alcohol dependency and restitution of the amount stolen. Of some interest is the fact that only $30 was stolen, a relatively small amount. The court ruled that the appellant had taken advantage of the victim's "frailties" and had imprisoned the victim in his own apartment during the robbery.

In *R. v. Thibeault* (1989), the accused was convicted of many counts of abusing persons with disabilities residing at the residential care facility that he operated. On appeal the sentence was essentially upheld.

With regard to sex offences, a sentence of four years was imposed in *R. v. Onalik* (1990). The case involved the repeated sexual assault of a deaf girl who had no verbal communication. The court gave particular consideration to the girl's feelings, to the protection of the public, and to the protection of persons made vulnerable on account of age or disability.[24]

Sentence appeal was dismissed as "without merit" in a case where the accused had been convicted of assault with a weapon, buggery and sexual assault of his two sons with intellectual disabilities. In this case, a 42-month prison sentence was upheld (*R. v. B.(R.H.)*, 1989).

In the sentence appeal of *R. v. Lucas and Friesen* (1983), the court held that the lack of threat against a 19-year-old paraplegic woman was not a mitigating factor for the sexual assault committed by the two accused. The court ruled that, because of her disability, no threat would have been necessary to have gained her submission.

In some cases, sentences have been increased on appeal. Concerning assault, this occurred in *R. v. McIntyre; R. v. Liron* (1992). The cases involved the vicious assault by several youths on a man with an intellectual disability. The man subsequently died as a result of complications arising from his injuries. The

most aggravating factor was found to be the accused's knowledge that the victim was "nothing more than a child, as regarded his intelligence and personality". Penitentiary sentences would probably have been imposed were it not for the age of the assailants. Sentences were increased by four months for each of the accused (to 18 and 24 months respectively).

Although not a sentencing case per se, in *R. v. L.(G.)* (1990) the Crown successfully applied to transfer two young offenders to adult court. The court considered the actions of the two accused particularly serious because the victim had an intellectual disability. The accused had physically and emotionally dominated him over a period of time, had tormented and beaten him into unconsciousness and performed other sadistic acts. They were ultimately charged with manslaughter and extortion.

Sentences have also been increased for sex offences against individuals with disabilities. In *R. v. Thul(R.P.)* (1992), the Crown successfully appealed to have the prison sentence raised from three months to four years. The case involved the sexual assault of a non-verbal woman with autism who had lived for several years in the care of the perpetrator. The Crown argued that the original sentence did not adequately reflect the seriousness of the crime nor adequately serve the purpose of deterrence. The court drew attention to the devastating effect of the incident on the survivor in that her trust and feelings of affection were violated and in that she was transferred from a family to a group home environment. The court held that deterrence and the protection of individuals with disabilities in foster and group homes was a paramount consideration in raising the sentence.

In another sex assault case, the Court of Appeal increased sentence from 25 days to six months' imprisonment in a case

involving a young female victim with a significant physical disability and her older male cousin (*R. v. S.N.*, 1986). The court held that the original sentence did not adequately provide for general deterrence nor reflect society's repudiation of the incident.

In some cases, sentences have been reduced on appeal. Typically, however, the courts have drawn attention to the seriousness of the offences under examination. For example, in *R. v. S.W.* (1988) the court pointed to the extreme seriousness of a young offender's extortion, under threat of physical abuse of a person with an intellectual disability. However, the court reduced sentence in the interests of the young offender's rehabilitation and employment.

Seventeen months' secure custody were given to a young offender for the kidnapping and extortion of $75 from a young man with a disability in *R. v. M.E.M.* (1988). The court implied that the virtual defencelessness of the victim aggravated the seriousness of the offence. However, due to special considerations that apply to young offenders, the sentence was later reduced to 12 months' imprisonment on each count, to be served concurrently.

In *R. v. Yorke* (1990), the accused had been charged with the attempted murder of a youth with a disability in the accused's care. The trial judge referred to the "stark horror" of the case and imposed sentence of 15 years. On appeal, however, the sentence was reduced to eight years because of mitigating factors relating to the background of the evidently troubled accused. In reducing sentence, the court did not seek to diminish the seriousness of the assault's effects on the victim.

In the case of *R. v. J.C.L.* (1987), sentence was reduced from four to three years. In this case, there was no question as to whether the accused had sexually assaulted his 17-year-old stepdaughter who had an intellectual disability. The court

referred to this as "an extremely grave crime requiring a prison sentence irrespective of his [the accused's] prior unblemished record to reflect society's abhorrence of this grave act". However, the Appeal Court found that the trial judge had allowed unsubstantiated allegations of other offences to be introduced at trial and had allowed this incidental information to influence the original sentencing decision.

Sometimes, the courts have underscored the seriousness of perpetrating violence against persons with disabilities but have imposed sentences that do not seem entirely consistent with deterrence or with society's revulsion. Certainly, prior to sentencing appeal, the cases of *R. v. Thul(R.P.)* and *R. v. S.N.* (discussed above) reflect this problem. Similarly, in *R. v. Wahpay* (1991), the accused was convicted of the manslaughter of a child with severe disabilities who was in her charge. Frustrated with the demands of care-giving, the woman threw the child to the floor at least three times and then beat him on the head with a hairbrush until he died. A sentencing consideration was that the crime was perpetrated against a defenceless child and that the court had an obligation to impose sentence that spoke out towards the protection of those who cannot protect themselves. The court knew that the accused had previous criminal convictions for aggravated assault. However, these did not involve incidents against children. The court imposed a sentence of only one year in prison and one year probation.

Similarly, in *R. v. B.(J.)* (1990), the appellant was convicted of sexually assaulting his niece who had an intellectual disability. The court stated that the family relationship and the victim's intellectual limitations placed the accused in a position of added responsibility. The added responsibility was found to be a factor that justified increasing the sentence. However, the court increased the sentence to only three months'

imprisonment. Somewhat peculiar is the significant disparity in sentences between this case and *R. v. Thul(R.P).* In the latter case, sentence was raised *from* three months to four years; in the former, sentence was only raised *to* three months.

Inspection and Licensing Provisions

The authority of provinces to inspect facilities has come under challenge in the courts. In *Director of Child Care Programs v. Venus Holding and Management Ltd.* (1991), the court found in favour of the province. In this case the day care operators held that inspections under the *Social Care Facilities Licensing Act* and regulations violated the unreasonable search and seizure provisions of the *Charter* (s. 8). The Alberta Court of Queen's bench found that there was no such violation and that the inspections were justifiable under section 1 of the *Charter* and were reasonable, routine, necessary and a lesser evil than the possibility of children being harmed or prejudiced. The courts have also upheld the mandate of provincial review boards to investigate, form their own conclusions and impose sanctions when they find provincial facilities at variance with provincial law and regulations (*Wilkins v. Provincial Child Care Facilities Licensing Board (British Columbia),* 1986).

In other cases, the courts have found the mandate of the province concerning inspections and sanctions to be unclear. For example, in *Re the Queen and Elm Tree Nursing Home* (1987), an Ontario nursing home was charged with violating provisions of Regulation 690 (1980) under the *Nursing Homes Act.* The trial judge found that subsections 5(2) and 5(3) were void on account of uncertainty and all charges relating to these provisions were prohibited. Provision 5(2) stipulated, "Every nursing home shall be so maintained at all times as to be free from anything that might be hazardous to the health or safety of the residents." Provision 5(3) held that each resident's needs

shall be regularly reassessed "and the resident's care plan shall be revised where the reassessment indicates that this is required". The judge's finding was not challenged on appeal. The court found that other sections of the Regulation left unclear whether breaches of the provision were to be considered as offences under the *Act* or instead as less serious matters to be dealt with through penalties such as suspensions or revocations of nursing home operators' licences.

Where there have been ambiguities, the courts have clarified the role and mandate of the province regarding the imposition of sanctions for a facility's non-compliance with legislation and regulations. In *Re Kagda Holdings Ltd. and Norton* (1984), the Ontario Court of Appeal held that the Nursing Homes Review Board had jurisdiction to order that a licensee remedy shortcomings in the operation of a nursing home. The court found that the board was not bound simply to revoke the operator's licence if there were concerns about the health or safety of residents or about other aspects of the home's operations.

A British Columbia court ruled that review boards, such as the province's Child Care Facilities Licensing Board, perform a quasi-judicial function. It also found that, without proof of malice, board members and persons reporting to the board are not personally liable in carrying out that quasi-judicial function.[25]

Another court in the same province found that, in certain circumstances, the licensing board is not liable for alleged damages when it fails to prevent the abuse of individuals who are receiving services. In *Madalena v. Kuun* (1987), the court found that the plaintiff had participated in consensual sex with her foster father. In this case, there was no question that the foster father had breached the law by having sexual relations with his foster daughter. However, on the matter of damages,

the court found that the foster daughter consented to sexual relations over a period of time; therefore, her claim for damages was dismissed.[26]

Notes

1. *R. v. Hawke* (1974). A similar ruling was upheld in the Ontario Court of Appeal in *R. v. Desmoulin* (1976), although the court also held that in light of the witness's mental history and her motive to exonerate herself, the trial judge should have instructed the jury to view her evidence with caution. The Ontario Court of Appeal also upheld in *R. v. French* (1977), that only in unusual circumstances could a witness's credibility be attacked by introducing the testimony of a psychiatrist when a lay person could, on the basis of the evidence, reach the same conclusion as a professional about a witness' testimony.

2. For other cases that look at the problematic nature of evidence provided by individuals with mental disabilities, see *R. v. M.(M.K.)* (1989), and *R. v. Baptiste* (1992).

3. In *R. v. Roy* (1994), where the accused was deaf and had no expressive communication skills, the case was dismissed. The individual's disability coupled with his lack of access to training concerning communication meant that he would not have been able to receive counsel concerning his rights under the law and to understand the court proceedings. The social failure to ameliorate the accused's communication problem resulted in his inability to participate on a fair basis in the trial proceeding.

4. The *Criminal Code* (s. 274) provides that corroborating evidence cannot be required with respect to certain sexual offences. As a matter of practice, however, corroboration is typically sought by Crown Attorneys to strengthen the credibility of complainant testimony. This is because the court needs to be convinced of the truth of the allegation beyond a reasonable doubt. Corroborated evidence is useful for that purpose. See The Roeher Institute, 1992a, p. 38.

5. See also *Nova Scotia (Minister of Community Services) v. B.(L.)* (1991), for the role of hearsay evidence of neighbours, social workers and medical personnel in an adult protection case.

6. This case involved an infant born drug addicted due to its mother's drug addiction.

7. The perpetrator of the assault was found liable to the plaintiff in damages for pain and suffering.

8. See also *Thwaites v. Health Sciences Centre* (1986).

9. See, for example, *Nova Scotia (Minister of Community Services) v. B.(L.)* (1991).

10. The case was a status review of the three-month guardianship order.

11. See *Ty v. C.L.M.* (1990), and *Ruszkowski v. Kozowy* (1987).

12. A similar outcome occurred in the case of *Director of Child Welfare (Newfoundland) v. J.M and G.M.* (1990).

13. The mother had an intellectual disability.

14. See also *Winnipeg South Child and Family Service Agency v. R.S. and A.P.* (1986), for a similar case.

15. This ruling seems to conflict with *Stoffman v. Vancouver General Hospital* (1990), in which it was found that hospitals are not to be considered part of government under the *Charter*.

16. Confinement of an individual is sometimes a preliminary requirement before administering treatment or care.

17. The surgery would likely have been ordered in any event. However, this does not alter the fact of a *Charter* infringement.

18. See *Kohn v. Globerman and Shane* (1986), and *Thwaites v. Health Sciences Centre* (1986).

19. In this case, the individual had an intellectual disability.

20. See the discussion concerning evidence and testimony in this chapter.

21. The *Criminal Code* establishes the general principle that persons younger than 14 years are incapable of providing adult consent to sexual activity and that alleged consent may therefore not be used as a defence. In this case, defence on the basis of consent was allowed because the girl was chronologically 14 years.

22. At the time this report went to press, the sentencing decision was awaiting the ruling of an appeal court.

23. Sentencing was actually reduced by one day to enable the appellant to participate in a rehabilitation program to which he would not otherwise have had access.

24. The disability of the victim was also considered an aggravating factor during sentencing in *R. v. Aqpick* (1988) (victim with intellectual disability); and *R. v. Kalinek* (1988) (robbery of elderly, blind victims).

25. *Harrington v. Pappachristos* (1992). At issue was the liability of board members and persons reporting to the board for the serious personal injuries sustained by a child at a residential care facility.

26. The case did not involve a complainant with a disability. However, the implications of the case could extend to persons with disabilities if a pattern of consent can be established concerning unwanted actions that occur under the aegis of licensing boards.

Conclusion

People with disabilities are more likely than others to be subjected to acts of violence and abuse that are proscribed by criminal and civil law. They are also subjected to subtle actions perpetrated by others that do not meet legal definitions of violence but that the survivors perceive as harmful. Contributing to their vulnerability are society's inability to clearly name and prohibit the problem. Further contributors are the often radically unequal social and economic position of persons with disabilities that places them at disproportionate risk and the lack of individual control and choice that makes it difficult for individuals to avoid and escape situations of risk.

Many obstacles impede survivors from disclosing acts of violence and abuse against themselves. The lack of proactive community and system measures to anticipate and look for signs of potential abuse and violence prevents the problem from coming to light. The luck of the draw seems to determine how family members, social workers, educators, counsellors, law enforcement officers and the courts respond to the problem: some individuals encounter empathic and effective assistance while the perpetrators are convicted; others face outright denial of the problem and little if any assistance while the perpetrators go free.

Existing legal, policy and program safeguards could conceivably aid in the identification, prevention and response to the problem. Some jurisprudence is emerging that suggests that society considers acts of violence and abuse against persons with disabilities to be particularly serious offences. However, given the apparent scale of violence and abuse against persons with disabilities, it seems clear that the legal, policy and program

framework is not working effectively. Justice is not being served. Meanwhile, frustrations mount and anger seethes.

What needs to be done to reduce the chances that violence and abuse will occur to persons with disabilities? What needs to be done to increase the chances that it will be disclosed and detected? And what needs to be done to increase the effectiveness of society's response to this urgent problem?

The challenge is not simple. The solution will likely require a holistic approach with necessary reforms and innovations on several fronts. To avoid the continuation of ad hoc and uncoordinated efforts, it would be helpful if the necessary changes were guided by comprehensive commitments and objectives. Perhaps most essential is public commitment to the principle that assuring people with disabilities freedom from violence and abuse is not a matter of charity but a matter of individual and citizenship rights. The laws of the land, the criminal justice system and public policy and programs are based largely on the notion that citizens are entitled to live in safety and security, respected and equal. These entitlements and the corresponding protections should effectively extend to all citizens, irrespective of ability.

Several key objectives arise from the research. First, addressing violence and abuse against persons with disabilities should be seen as a matter of promoting and safeguarding the equality of persons with disabilities as citizens and under the law. A remedy simply must be found to placing an entire group of persons in situations where they are disproportionately more likely than others to be at risk, to experience harm and to find that violence and abuse are not effectively addressed by the state. All stakeholders in the well-being of persons with disabilities need to better understand that violence and abuse are indeed occurring on a significant scale and that many factors — which can be changed — render individuals vulnerable. Second, all

stakeholders need ways to address, in their respective spheres, the risk factors that make individuals vulnerable, that silence disclosures and obstruct detection and that nullify and confuse responses to survivors. Each of the stakeholder groups then needs to set about making the necessary changes in perception, attitude and practice that will result in coordinated efforts to prevent, and respond to, this distressing situation.

With these objectives in mind, directions for change can be identified. Social policy and administrative and program reforms need to be coupled with community development initiatives that will strengthen the capacity of communities to identify and address the problem. Statutory reforms would bring clarity and power to these initiatives. For changes to occur, effective public education and public awareness efforts need to be mounted. Data gathering and research also need to be more systematically conducted to support efforts on these fronts.

Policy, Program and Administrative Reforms

Systemic Reforms

Policy and program arrangements that create situations of increased vulnerability to violence and abuse for persons with disabilities need to be confronted and reformed. On a broad systems level, unacceptable numbers of persons with disabilities are socially and economically marginalized. This results in too many persons with disabilities being in situations where they are at risk of violence and abuse and have limited means to remove themselves from those situations. Systemic reforms are required that will assure more equitable participation of persons with disabilities in education, training and the labour force. Individuals who are unable, for whatever reason, to make

provision for their own economic security should have access to income security arrangements that will provide adequate levels of support so they can avoid living in social and economic circumstances where they are likely to be at risk.

Service Reforms

Social, health and mental health services are in need of major reforms so they will be more respectful and accommodating of the individual choices of persons with disabilities. Funding and service arrangements should empower individuals with disabilities and maximize their choices instead of disempowering them and placing them at risk. Consumers should have much greater control over the forms of support to which they have access and over who provides that support and how. When the consumer deems a particular support provider to be inappropriate or dangerous there should be no policy, program or funding obstacle to alternative arrangements.

In particular, social policy and programs need to be designed to ensure that persons with disabilities have access to alternatives to segregated living, educational and work situations so they can increase their contact with members of the community at large. Policy and program innovations are needed to enable individuals to avoid and to counterbalance the social isolation and devaluing that happen through segregation and that increase the chances of being victimized.

Clear and Consistent Definitions of Abuse and Violence

It would be helpful if clear operational definitions of acts and omissions that constitute abuse and violence against persons with disabilities were developed and incorporated, consistently, in *all* policy that pertains to *all* funded, licensed or approved services that address the needs of persons with disabilities.

These would apply to public, voluntary or for-profit services. All services should be held accountable for developing internal procedures to facilitate the identification, reporting and timely response to victimization. All human service agencies could be faced with the prospect of stiff penalties if they fail to develop these procedures and if they fail to educate their employees concerning them. These measures would incorporate incentives and protection for "whistle blowers".

Model Administrative Practices

Consideration also needs to be given to embedding in provincial and territorial policy those features of proactive administrative practice in the services sector that are critical to the timely detection, reporting of and response to violence. Such model practices could be required as standard operating procedures on a sector-wide basis.

Incentives and penalties should be developed to ensure that administrators in the service sectors properly screen job applicants for criminal histories or previous professional misconduct that could jeopardize the safety and well-being of persons with disabilities. Also useful would be a centralized data registry with the following information on employees or job applicants in the service sectors: past criminal convictions for offences against persons; previous civil penalties that suggest the individual is unsuited to the human services; and appearances in court for serious allegations of misconduct under criminal or civil codes for behaviour that has the potential to negatively affect the well-being of persons with disabilities. Some means of monitoring should also be devised that tracks the behaviour of persons alleged to have committed serious offences but who are not charged or convicted and who intend to enter, or to return to, the service sector as employees.[1]

Less Discretion to Ignore the Problem

The discretion of administrators to ignore allegations of abuse and to reassign alleged abusers to other positions within the organization needs to be strictly curbed. Perhaps over and above agency reporting and investigation procedures, some form of crisis line is needed so that survivors and witnesses of abuse can obtain counselling and other assistance short of calling the police.

Greater Accessibility of Community Services

Police and social services that serve the general population need to take more active steps to ensure that their organizations' resources are accessible to all members of the community, irrespective of ability. Accessibility can be improved to enable more survivors to report violence and abuse. Adaptations to the physical environment, TDD phone lines and arrangements to bring in community resource persons to facilitate the survivor's communication are all important accessibility measures. Service agencies should consult with disability organizations to determine the permanent accommodations needed, as well as the accommodations that may be needed in particular cases and how these can be obtained. Wider use of personal safety technologies such as electronic alarms that link home telephone lines to police and other agencies could also increase survivors' access to agencies in a position to respond.

The development of, and compliance with, accessibility standards is necessary to make court facilities and Crown attorneys' offices accessible to persons with physical disabilities. Such accessibility standards would include procedural guidelines and sources of assistance that the courts can tap when a witness has an expressive communication disability, limited literacy skills, learning difficulties, a sensory impairment or other limitation that potentially affects his or her ability to participate on a fair and equal basis in a court proceeding.

Greater Responsibility for Providing Effective Services

Governments should consider using funding and policy measures to ensure that the various organizations involved in fielding survivors' complaints of abuse and violence make it a priority to: a) include victims with disabilities among their clients; and b) develop their competencies so they can effectively address the complaints of persons with disabilities.

Affordable Services

Provincial and territorial governments should also ensure cost coverage of psychologists and other forms of counselling for survivors with disabilities. Provision has already been made under federal-provincial agreements such as the Canada Assistance Plan (CAP) to cover the costs of "non-insured health care services" and other services for persons in need or likely to be in need. Persons with disabilities have been defined for the purposes of CAP as a community of persons likely to be in need. CAP or a variant of CAP could be used as a funding mechanism to ensure that the required services are in place, affordable and accessible.

Procedures for Better Coordination and Collaboration

Clear procedures need to be developed within and across the following sectors concerning how to arrange the necessary referral and other supports for survivors: social service agencies; advocacy organizations; health and mental health care providers; the police; and the legal profession. Governments could show greater leadership and the voluntary and policing communities could demonstrate initiative by pioneering inter-agency agreements and standard procedures for fielding complaints that involve individuals with disabilities in various settings. These settings would include: family homes; school, training and occupational development centres; health facilities including

mental health and rehabilitation facilities; developmental services facilities; group homes; foster care arrangements; special care homes; lodging and rooming houses; independent living and supported independent living arrangements; apartment buildings and other multi-dwelling arrangements; and recreational facilities such as community centres.

More Proactive Police Measures

To promote speedy police responses to complaints involving persons with disabilities, procedures at police communication centres could be modified to include an electronic listing of addresses where persons with disabilities are known to reside. This information is already available from Statistics Canada, in electronic form, for many thousands of small group homes, large residential care facilities, rehabilitation facilities, psychiatric treatment facilities and hospitals in every part of the country.[2] The information could be linked with other data technologies, such as those used by fast food outlets to identify consumer names and addresses by means of telephone numbers. The data could be used to flag incoming calls from places where persons with disabilities reside — precautionary information that dispatchers can pass onto beat or investigating officers. The information could also be used to strengthen proactive community policing initiatives.

Better Support for Families

Public measures should be introduced that recognize the additional stresses on family members caring for individuals with disabilities. Non-intrusive, non-stigmatizing and supportive financial, educational, counselling and emotional assistance should be made more available to families who indicate a need so stresses on families can be resolved before they escalate into violence and abuse.

Community Development

Community Capacity to Include Persons with Disabilities

Disability consumer, advocacy and other organizations with a stake in the well-being of persons with disabilities should be encouraged and, if necessary, funded to mount community development initiatives that will break down the social isolation of persons with disabilities. These initiatives could also increase awareness of signs of potential abuses against isolated individuals. Particularly useful are self-help groups for survivors, which can provide a safe context for talking about and working through traumatic events.

Advocacy Supports for Survivors

Also needed are advocates in the community who are knowledgeable about what it means to live with a disability and to be abused. These advocates can be informed about the systems to help survivors take a stand against their perpetrators. Advocates could play an important public education role by raising awareness in the community about the prevalence, nature, causes and remedies of violence and abuse against persons with disabilities.

Proactive Outreach

Agencies responsible for fielding complaints of violence and abuse (e.g., the police, women's shelters and counselling centres) should take steps to become more aware of persons with disabilities residing in the community. These agencies should implement measures to establish communication and outreach with such persons.[3]

Statutory Reform

Model Legislation

Serious attention needs to be given to developing model legislation that will: actively recognize and prohibit the various forms of violence that are occurring against people with disabilities; ensure survivors have opportunities to bring their victimization to the attention of the courts and have their cases fully heard; limit the discretion of the courts to dismiss the testimony of complainants; and reduce the need for survivors to trade away their liberties in exchange for protection.

Clearer and Broader Legal Sanctions against Violence and Abuse

It would be useful if criminal and civil sanctions against the abuse of persons with disabilities by government-licensed or funded operators of services were more clearly spelled out in law. The *Criminal Code* should clarify the notion "necessaries of life" in the event of disability. The *Code* should also be amended to include specific prohibitions against the verbal and psychological abuse and mistreatment of persons who rely on others for their care and support.

In the same way, provincial and territorial legislation should clarify what is meant by emotional, psychological and verbal abuse. Consistent definitions and sanctions need to be embedded in legislation across departmental lines so individuals are not afforded lesser protection simply because they happen to fall under a piece of legislation that affords lesser protection. Included within notions of abuse would be harmful acts that fall short of causing injury, endangerment of health, disability and other egregious harms, but that are nonetheless unacceptable, socially and ethically.

Clarification Concerning Freedom to Escape Danger

Clarification is required concerning the *Criminal Code* principle that persons with disabilities who are unable to withdraw themselves from the care of others are to be accorded special legal protections. There should be a clearer delineation of factors specific to having a disability, such as the lack of alternative circumstances or support services, that may leave survivors feeling that they have no option but to remain in abusive and violent situations. That is, the *Code* should provide for situations where factors aside from functional impairment can seriously limit an individual's ability and liberty to remove themselves from a dangerous situation.

Consistent Standard of "Harm"

The level of harm that renders acts and omissions against persons with disabilities in the care of others criminal offences needs to be reviewed. It is a criminal offence to commit acts or omissions that result in endangerment of the life or health of an individual with a disability who depends heavily on another person's care. However, the level of harm that is considered an offence in relation to a dependent child or spouse is simply the failure to offset destitution or "necessitous circumstances". Why is this lesser standard of harm not the litmus test of criminal offences against individuals with disabilities who are reliant on others?

Consistent Standard of Consent

In cases where lack of consent to an action renders the action an offence, a clear standard should be developed to allow the courts to make determinations beyond a reasonable doubt as to whether, by reason of a mental disability, an individual could not have consented to such an act (e.g., anal intercourse). That same

standard should then be applied to *all* other acts against individuals with mental disabilities which, in the absence of free and informed consent, would be considered criminal offences.

Legislation Not Limited by Program Criteria

Legislation and regulations should extend sanctions against abusers in *any* situation where persons with disabilities are receiving disability-related services. These situations should include publicly and privately financed care in facilities and other settings. Sanctions should apply not only to staff in facility-based care and service settings but also to people in other settings including the victim's home. This measure would include extending the prohibitions against verbal and emotional abuse in child care settings to cover children receiving early childhood intervention services in the family home. Legal prohibitions against the verbal and emotional abuse of adults in facilities should be extended to protect adults with disabilities receiving any form of funded, licensed or regulated service in the community relating to their disability. This would include attendant and homemaker services provided in the private home and occupational training support in sheltered and mainstream employment settings. The duty to report such abuses to provincial or territorial authorities could be imposed on all service agencies and organizations.

Clearer Sentencing Provisions

Criminal Code sentencing provisions concerning sexual touching and invitation to sexual touching should be increased. Sentencing provisions should reflect the principle that such offences are particularly serious where the complainant is dependent on the accused or where the accused is in a position of authority and trust.[4]

The Unfettered Provision of Testimony

Provincial and territorial evidence acts that undermine the value of uncorroborated evidence provided by persons with intellectual or psychiatric disabilities should be struck down. At the very least, everyone should have the right to provide evidence and the evidence should be judged on its own merits.

Legal Reforms Consistent with Individual Rights and Freedoms

To prevent situations of abuse from arising and from finding protection in law, provincial statutes and regulations should be harmonized with the principle articulated in case law that services for persons with disabilities that are provided, funded or licensed by the state should be consistent with the right of individuals to privacy and to independent living. Moreover, although the intention behind neglected adult and adult protection legislation might be laudable, it can also be argued that placing adults under state protection to assure their personal security can be a serious infringement of ordinary freedoms. Less invasive legal instruments should be developed to protect individuals from harm and to deter and punish perpetrators. These measures should be designed to ensure that the individual liberties and independence of survivors are safeguarded and promoted.

Similarly, mandatory reporting provisions might impress on alleged or would-be perpetrators the seriousness of offences against persons with disabilities. These provisions, however, can be problematic. Depending on the legal framework, mandatory reporting can trigger a chain of investigations and other events that survivors may perceive as invasive and against their own best interests and preferences. Although mandatory reporting may have merit, it is not clear that mandatory intervention by the police, social workers and departmental ministers is an unqualified benefit. Instead, interventions should

be guided by the survivor's express wishes. Survivors should have the option of pursuing administrative rather than judicial processes to address violent or abusive incidents, if they wish.

Education and Awareness-raising

It is important that the people who most need to be informed have access to the findings of current and future research. Family members, educators, social workers, human service personnel, law enforcement officials, lawyers and the judiciary all need information concerning why and how people with disabilities are being victimized, effective measures that have been taken to date and further measures that need to be adopted to address the problem.

Public Awareness Campaigns

Public awareness campaigns need to be devised to show that persons with disabilities are valued human beings with a full range of perceptions and feelings. The campaigns would tell how persons with disabilities are being victimized and describe the impact of victimization on individual lives. Abusive and violent acts need to be clearly portrayed as unacceptable, as happens in some public awareness and prevention campaigns against wife assault and child abuse. Persons with disabilities should be informed about the agencies and individuals available to field complaints of violence and abuse. Advise about bringing complaints forward, the costs of doing so and other details should be included in the awareness campaign. Government, voluntary groups and even the private sector have a role to play in supporting such campaigns.

Individuals with disabilities and their family members should be clearly informed about what constitutes abuse under

law, social policy, regulation and individual service agency policy. They should be informed about the legal and administrative channels open to them for reporting abuses.

Information and Training for Persons with Disabilities

Based on statutes and case law, a generic consumer bill of rights could be developed and provided to all persons with disabilities who are receiving disability-related services, whether publicly or privately financed. The brief document would clearly communicate the federal and provincial provisions that impose sanctions against various acts of violence. An appendix to the document could outline the channels of redress and how to gain access to them in a particular province or territory.

Family members (and paid providers of support) should be encouraged and assisted to ensure that they educate family members with disabilities — particularly young persons — concerning their human rights and the behaviours of others that are ethically and legally unacceptable. Adults with disabilities who do not have a basic understanding of unacceptable actions should be provided with the appropriate information, probably in discussion group format. Individuals who have suffered repeated abuses and who may have grown desensitized to abuses against them should have access to empathic support groups and counselling services so they can regain their perspective.

Regardless of whether they have been victimized, persons with disabilities should have access to education, discussion groups and other opportunities to develop a personal sense of confidence, control and assertiveness in relation to abusive situations and perpetrators. Wider access to affordable assertiveness training and self-defence classes may be useful preventative measures.

To assure equal participation in the criminal justice process, access to sign language training for persons who are deaf or hard of hearing, as well as access to alternative forms of communication (e.g., Bliss Symbolics) for individuals with other communication difficulties, should be considered a right not a privilege. The public education system and adult education systems should ensure that this right is accorded.

Information for Family Members and Service Providers

Family members need access to education and sensitivity training regarding the signs of violence and abuse against members with disabilities and how to respond in a supportive manner. The same is required for workers in the social service, health care and educational community. These initiatives should not induce panic and hysteria but empower participants to take reasonable steps to anticipate, detect, prevent and respond to the problem of violence in a competent manner.

Greater publicity should be generated in the service sector concerning the sanctions that can be, and that have been, drawn upon to punish individuals whose actions are contrary to the *Criminal Code*, provincial statutes and departmental policies. Counsellors in community agencies should have access to training concerning how to tailor their services to the needs of individuals with particular disabilities.

More sensitivity training is required for police officers to help them interact with survivors with disabilities in an appropriate manner. Police officers should also be encouraged to establish greater contact with the disability community in non-crisis situations so that they will feel more comfortable serving this large and growing segment of the population.

Officers should be educated about difficult cases that have successfully moved through the criminal justice system and

that resulted in perpetrators being sentenced. Perhaps a case study approach would be a good way for officers to examine successful and unsuccessful ways of conducting investigations in these cases. It may also allow investigating officers to consider why the testimony of survivors with disabilities has sometimes been accepted in court despite witness contradictions on points of detail, which are sometimes used against the credibility of witnesses. Similar educational opportunities might be useful for lawyers, the judiciary and others involved in the criminal justice process, including advocates, adult protection workers, service providers, counsellors and family members.

Information for the Legal Profession and the Judiciary

Advocacy and disability organizations have a role to play in educating the legal profession and the judiciary concerning what it means to have a disability, the situations of risk for individuals, the factors that make those situations dangerous and the forms of harm to which individuals are subjected. Education should also be provided on the power relations that tend to prevail between perpetrators and victims and why they prevail and the perceived inefficacy of the criminal justice system and measures for improving it.

In particular, the judiciary and legal professions should be educated about typical power relations in care settings that can render residents and other persons in care particularly vulnerable to violence from professionals and para-professionals. The courts should be encouraged to use this information when assessing the credibility of testimony provided by professionals and other care providers against that of complainants with disabilities.

The university and in-service training of legal professionals should include relevant, up-to-date information about the abilities of people with disabilities and a critical analysis of

stereotypes that can lead to unfair treatment of people with disabilities in the trial process. Education is also needed for the legal profession concerning the rules that have evolved for leading evidence about a witness's disability for the purposes of assessing — and discrediting — a witness's credibility. On the basis of the rules, judges should assume some responsibility for curbing defence attorneys who attempt to lead evidence concerning a witness's disability when such evidence is either patently false, based on stereotypes or incidental to the case.

To prevent inappropriate rulings in the event of child abuse, courts should be informed of effective, non-violent methods of parental discipline for children with severe disabilities, so the courts can: a) judge the appropriateness of parents' use of physical force; b) adopt a coherent and just approach to differentiating between unacceptable violence and the responsible use of physical force for the purposes of child discipline; and c) in sentencing, make recommendations concerning counselling, parenting skills training, family support strategies and other supports that might assist parents who have difficulties managing the behaviour of children with disabilities.

Information for All Stakeholders

All who have a stake in the well-being of persons with disabilities need to become better aware of the systemic factors that make survivors fearful about disclosing abuse and violence. Using this information, stakeholders should analyze the environments in which people they know are living, learning, working or recreating and identify potential risk factors that may be silencing them. Active intervention strategies may then be needed to prevent, detect and respond to the problem. All stakeholders should educate themselves concerning current legal and policy provisions to protect persons with disabilities

from violence and abuse and to respond to the problem once it occurs so these provisions can be more widely used.

Data Gathering and Research

Government Research Units

Research is required in several areas. First, the nature, extent and causes of violence and abuse that occur in community and in institutional settings against persons with disabilities need to be better understood. To that end, Statistics Canada's Unified Crime Report (UCR) format should be modified to require police departments to systematically gather data concerning whether victims have disabilities. Since the UCR drives police data gathering, without changes to this process, it will be extremely difficult to monitor the number and nature of reported complaints of violence and abuse against persons with disabilities. Nor will it be an easy matter to assess whether conviction rates are appropriate.

Second, national statistical surveys, such as the General Social Survey (GSS) on Personal Risk and the Violence against Women survey, should be used as bases for a thorough analysis of the victimization of persons with disabilities.[5] The Health and Activity Limitation Survey could also include questions on violence to individuals after the onset of disability. To date, the HALS household survey asks only in the most cursory way about acts of violence that *result* in disability. The HALS institutional survey could also include a few questions on forms of violence that this and other research clearly indicate is occurring in various institutional settings.[6]

Based on the survey data described above, government research units such as the Centre for Justice Statistics should disseminate facts and analysis on violence against persons with

disabilities through its Service Bulletin and other publications. Other research organizations could be encouraged to engage in this work as well, perhaps in partnership with the Centre for Justice Statistics.

In particular, systematic analysis is required concerning the gap between the violence and abuse that is occurring and responses by the criminal justice, social service, health and educational sectors.

Legal Research Community

The legal and court systems need to be strengthened so that the harms that many people with disabilities are experiencing are clearly recognized and proscribed in law. For this to happen, data gathering and documentation procedures within the police and court systems must be improved to provide a better understanding of alleged victimization cases that are never brought to court or that are brought to court but dismissed.

The underlying reasons why persons with disabilities are not believed when disclosing violence and abuse need to be researched and better understood. In particular, stereotypes and false assumptions about complainants with disabilities need to be critically reviewed and exploded.

As a means of establishing bench marks and probabilities, research is required into the ways particular disabilities can affect a witness's testimony, the conditions under which this can occur and the probability that this will actually occur in court. This data and analysis could be used in defence of witnesses with disabilities whose credibility is attacked by innuendo, that is, because they have a disability.

Cases in which the inconsistent testimony of witnesses with disabilities has been admitted to court and used for the purpose of conviction should be studied. The features of the testimony

that the courts have considered pertinent should be clearly identified, as should extraneous features. On the basis of this analysis, principles and rules could be devised to assist the courts in performing a thorough and fair evaluation of the testimony of witnesses with disabilities. The analysis would also assist the courts in distinguishing the essential from the extraneous in witness testimony.

Legal research should be conducted into forms of non-visual evidence that have been accorded status in courts of law (e.g., evidence as to an accused's odour obtained by a tracking dog). Evidentiary principles could be extracted on the basis of this research and disseminated broadly within the criminal justice system (police, lawyers, judiciary) so that non-visual evidence provided by persons with sensory impairments will receive due recognition and status in the criminal justice process.

Research into statutory provisions, case law and social policy is required to clarify the state's legal mandate, responsibility and role concerning the provision of disability-related supports — the denial of which persons with disabilities and the courts might construe as abusive.

Case law should be studied to clarify the difference between notions such as prospective and actual or imminent harm to self or others, to assist the courts in assessing the legitimacy of statutes and orders that have been used to restrict the liberties of persons with disabilities. Statutory provisions and case law should be researched as a means of establishing bench marks to assist the courts in making reasonable determinations concerning whether, in light of a complainant's intellectual, psychiatric or other disability, he or she is capable of giving consent to activities that are offences in the absence of consent.

Based on the research of legislation and case law, it would be useful if a systematic rationale were devised to assist the courts in consistently weighing the seriousness of offences

against persons with disabilities. Also necessary is research concerning precedents for the purposes of sentencing in cases where persons with disabilities have been victimized. Proposed and experimental sentencing provisions that hold some promise of providing the necessary deterrence and punishment to perpetrators could also be investigated.

Other Researchers

Union contract provisions in the social service and health sectors need to be examined to identify provisions that may leave persons with disabilities at risk of physical, verbal and emotional abuses, including the neglect and denial of essential needs. Alternatives to these provisions should be explored and new models devised. These alternative provisions should balance the need for the occupational health and safety of organized labour with the dignity, rights and needs of the consumer.

A thorough examination is required of models of community agency administrative practices that are proving useful in addressing violence and abuse against persons with disabilities. Information about effective models should be widely disseminated.

Finally, the appropriateness and effectiveness of professional self-regulation as a means of stemming and responding to care-giver violence against people with disabilities needs study. Given the scope of the problem, common sense suggests that current self-regulatory approaches have not been entirely successful. What are the alternatives, particularly for professionals and para-professionals in the health care and social service fields?

The Benefits of Change

Implemented one step at a time, the above recommendations may offer people with disabilities the knowledge, skills, resources and decision-making control they need to avoid harmful situations and to report them with confidence that they be resolved. The suggested initiatives would also help communities avoid putting people at risk in the first place. The initiatives would increase the likelihood that communities will detect the signs of violence and abuse when it occurs and they empower communities to take proper steps to limit the impact of violence on individuals with disabilities and deal appropriately with perpetrators.

As one advocate commented, "The model is to build a caring community. ... That's what it comes down to." Another said, violence "is built into our culture and into our society ... that's what has to change. Respect for other people from the time they're little kids. ... It's a whole change in our attitudes that has to happen. Consequently, it has to happen in the courts, in our education system, in our religious system — the whole thing."

Notes

1. This last suggestion may be difficult to implement in light of individual privacy rights and the presumption of innocence that also have to be safeguarded.

2. The data are available for Residential Care Facilities and Hospitals, as reported semi-annually in the Health Reports series.

3. The early political demands for the establishment of the Advocacy Commission in the province of Ontario were based in part on recognition of the need for a proactive approach to the problem of violence and abuse against persons with disabilities.

4. This point has already been established in case law.

5. For this to occur, the GSS sample may need to be increased and certain changes will need to be made in the questionnaire that make it possible to distinguish more clearly the types of disabilities that victims have and the places of victimization. Presently, the questionnaire on personal risk asks only a single screening question about disability, unlike the battery of questions on disability used in the GSS health survey. Moreover, a particular GSS question about place of victimization makes it difficult to differentiate between violence in hospitals, rehabilitation centres and prisons. Although these are all "institutions", they are different social environments with different risk factors; therefore, the question should be worded accordingly.

6. Admittedly, such questions might prove awkward for the administrators of institutions in which respondents are surveyed.

Appendix 1. Statistical Tables

Source: Statistics Canada, (1986) Health and Activity Limitation Survey of Adults Living in Private Households.

Table A1.

Adults with and without disabilities, by living arrangement and whether living below Statistics Canada's "low income cut-off" (showing numbers and percentages)

	Without disab.		With disab.	
	Number	%	Number	%
Total	**2,318,810**	**13.9**	**710,380**	**25.4**
Son/daughter in census family	371,070	11.8	41,650	22.7
Husband/male common-law partner	427,580	8.6	140,900	15.7
Female lone parent	244,650	43.1	59,480	46.8
Male lone parent	15,090	12.9	9,070	30.7
Wife/female common-law partner	471,820	9.2	103,480	14.6
Other family member	99,760	16.4	30,720	15.8
Alone	395,050	27.8	261,250	50.0
Unattached, with non-relatives	293,790	45.3	63,830	60.6

Table A2.

Adults with disabilities who never visit family or friends outside their own residence in a given month, do not engage in social activities inside their own residence with family or friends in a given week, do not converse by telephone in a given week and who fulfill all of those criteria (i.e., no contact) (showing percentage)

	Never visit family/ friends o/s residence in a month	Never visit family/ friends in residence in a week	Never converse by telephone in a week	No contact
Rural	11.1	15.8	35.8	3.2
Urban< 1 million	12.8	17.0	27.9	3.8
Urban 1 million +	13.9	21.7	21.6	2.9

Table A3.

Persons with disabilities in various census metropolitan areas who do not visit friends or family either outside (monthly) or inside (weekly) their own residence and who never (weekly) converse with others by telephone (showing percentage)

Total	3.5
St. John's	5.3
Halifax	3.4
Montreal	4.9
Toronto	1.1
Winnipeg	4.3
Calgary	4.5
Edmonton	1.4
Vancouver	3.7
Other urban	3.9
Other rural	3.2

Individuals living in Edmonton and Toronto are less likely to be completely isolated than those in Montreal, Calgary and Winnipeg.

A relatively high degree of complete social isolation occurs in rural Quebec (5.8 per cent) and Newfoundland (5.1 per cent). In contrast, rural Alberta has very few individuals with disabilities who are completely isolated (1.1 per cent).

Table A4.

Persons with principal disability and several disabilities, by type of disability who do not visit friends or family either outside (monthly) or inside (weekly) their own residence and who never (weekly) converse with others by telephone (showing percentage)

	Principal	Several
Total	3.5	3.9
Mobility	1.1	3.8
Agility	1.2	4.0
Seeing	4.6	5.9
Hearing	3.2	4.5
Speaking	4.1	10.8
Other	9.6	6.3

Persons with several disabilities have more than one of the disabilities indicated on the table. Persons whose principal disability is in a given category have no other disabilities. Whether or not people are socially isolated depends in part on their disability. For example, a high proportion (9.6 per cent) of individuals whose only disability is in the area of mental health or intellectual functioning are socially isolated.[1] A high proportion (10.8 per cent) of persons with several disabilities who have difficulties with speaking also have little social contact with family or friends.

1. These are persons classified by HALS as having "other" disabilities, that is, disabilities that are not in the areas of mobility, agility, seeing, hearing or speaking.

Table A5.

Adults with disabilities, by gender, highest level of education and whether familiar with where to get information on human rights (HALS G12 = Yes) (showing numbers and percentages)

	All	Yes	Female	Yes	Male	Yes
Total	2,794,550	38.3	1,468,240	36.8	1,326,290	39.9
Primary only	1,045,280	32.6	568,970	30.3	476,310	35.4
Some high school	715,920	36.7	381,830	35.8	334,080	37.8
High school graduate	227,250	41.4	130,240	42.2	97,010	40.3
Trades certificate	242,990	42.9	87,230	41.3	155,760	43.9
Some post-secondary	211,570	42.2	99,830	40.5	111,740	43.7
Post-secondary cert.	232,380	48.9	149,830	47.7	82,540	51.0
University degree	119,160	54.0	50,310	57.4	68,850	51.6

The totals in the All, Female and Male columns represent the total weighted samples (yes, no and non-responses) for each education level.

Appendix 2. Methodology

The research used a multi-strategy methodology. An extensive literature review was conducted to examine what other researchers and analysts have had to say about the issue. The literature review has been prepared as a separate document and can be read in conjunction with this one.[1]

A review of federal, provincial and territorial legislation was conducted to examine statutory protections and sanctions against various harms to persons with disabilities. The review included provisions that deal with physical abuse, sexual abuse, verbal and emotional abuse, harassment, neglect and other criminal and civil offences proscribed under the *Charter*, the federal *Criminal Code*, federal, provincial and territorial human rights legislation and numerous pieces of social service and mental health legislation. Statutes concerning the provision of evidence in courts of law were also included in the review, as were laws relating to guardianship and adult protection. All pertinent federal, provincial and territorial laws were examined.

A select, yet reasonably comprehensive and detailed, review of case law was conducted. Again, federal case law and case law from each province and territory was examined. The purpose of the review was to identify and analyze principles the courts used in judgements and sentencing in cases involving violence, abuse and other violations against persons with disabilities.

A select review was made of policy and program arrangements at the provincial, territorial and community level that have a bearing on the conditions that place individuals at risk, that affect the reporting and detection of abuse and

that have a bearing on the conditions that place individuals at risk, that affect the reporting and detection of abuse and violence, and that can shape responses to violence once it has been identified. The purpose of this review was to gain insight into the diversity of current policy and program arrangements, not to provide an exhaustive policy and community program analysis.

Statistics Canada's 1986 Health and Activity Limitation Survey (HALS) data were analyzed for the prevalence of conditions in the lives of persons with disabilities that are associated with risk. HALS is a major source of statistical data that can illuminate the social and economic situation of people with various disabilities in Canada. Unfortunately, the 1991 data were not available for public use when this document was being prepared.

Interviews were conducted across Canada with self-selected individuals with disabilities, many of whom have personally experienced abuse and violence. Respondents were interviewed in each province. However, because of resource constraints, face-to-face interviews could not be conducted in the Yukon or Northwest Territories.

Representatives from a large number of disability and advocacy organizations were asked to collaborate by making initial contact with individuals whom they knew had been victimized and who would feel comfortable talking with interviewers about the situations in which they had been harmed. Only individuals who volunteered to participate were invited to take part in the interviews. L'Institut Roeher Institute considered the self-selection of respondents to be an essential ethical safeguard to avoid the problem of re-victimization.

An effort was made to ensure an even balance between male and female interview respondents with disabilities. This proved more challenging than anticipated. It was more difficult

to identify males who had been victimized and were prepared to discuss it. This may reflect the possibility that females are more likely than males to be victimized, or that males feel more inhibited than females discussing situations in which they have been harmed. Until statistical analysis based on a large sample of persons with disabilities is conducted, it is not possible to determine precisely why more females than males seem prepared to talk about violence and abuse in their lives.

An effort was also made to include interview respondents who represent Canada's racial diversity. Several Aboriginal persons were interviewed. However, people of colour and Aboriginal persons have a limited presence in the disability and advocacy organizations that provided assistance to the project. Therefore, the interview sample does not fully reflect the country's diversity. The statistical sources that were consulted, however, do include the entire spectrum of individuals with disabilities in Canada. The statistical data and analysis provide insight into the social and economic situation of persons with disabilities as an entire group.

Interviewers were trained to be as sensitive as possible to the responses of interviewees and to respect any limits required by interviewees who had been victimized, including wanting to end the interview. Although these precautions were taken, it was not possible to entirely shield interview respondents from the pain of reliving violent situations. Seventy-one persons with disabilities took part in the interviews and several of these interviews were terminated because the incidents were too painful for the respondents to recount.

It was anticipated that some individuals would experience emotional stress while telling their stories, particularly in face-to-face interviews. Arrangements were made for the necessary counselling and other emotional supports and in several cases these supports were used.

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It was also anticipated that interviewers might experience stress and anguish while listening to people tell their stories. In some instances, interviewers were appalled at the level, scope and impact of the violence and abuse that had invaded the lives of interview respondents. Interviewers often felt remorse at having to leave participants in situations that were far from ideal. Emotional supports were made available for interviewers.

Given that a qualitative research methodology was used in the interviews, the project proved to be a learning experience. A detailed and structured interview questionnaire.was designed to capture both brief and discursive interviewee responses concerning the harms they had encountered and others' responses to their victimization. Due to the sensitive nature of the subject and the depth of feeling and scope of memory that opened up, the interviews, as expected, took on a life of their own in many cases. It would have been artificial, insensitive and unrealistic for interviewers to impose the structure of the questionnaire on interview participants and to exact compliance with this structure. Accordingly, interviewers sometimes used the questionnaire as a general guide or as a reminder to pursue issues that did not surface during the natural flow of the conversation. After the interviews were concluded, many of the respondents' comments were classified according to the data categories used to design the questionnaire. However, several kinds of interviewee response were not anticipated during interview design and pretesting and so could not be made to fit into the established structure. Coding procedures were revised to include these responses.

Another development during the interviews was the readiness of not all, but many, participants to tell their story. It was initially assumed that respondents would perhaps need some time to feel comfortable and safe enough to respond to questions concerning abusive and violent actions they had

personally experienced. Participants were asked several questions as ice breakers, which had them speak about their life in general and about harmful acts that had occurred to one or more people whom they knew. Several participants were impatient with this approach and wanted instead to get to the details of their own stories. Interviewers moved with the natural dynamic of the interviews. Sometimes, the interviews went far beyond the 90 minutes initially planned.

Interviews and focus groups were conducted with counsellors and social workers involved in fielding complaints of abuse and violence against persons with disabilities. Several of these individuals had disabilities. Interviews and focus groups were held with a sample of police officers and police administrators from across the country, as well as with community advocates, administrators and service providers attached to community agencies that serve persons with disabilities. Family members of persons with disabilities who have been subjected to violence were also part of focus groups and interviews. In all, the interviews and focus groups involved 120 interviewees.[2]

In addition to routine orientation and de-briefing sessions with interviewers, a day-long session was conducted with the interviewers towards the end of the interview process. This allowed them to share with l'Institut Roeher Institute administrators, senior research staff and one another some of the insights that emerged during interviews. The transcript of the discussion served as another source of data that enriched the primary interview data. The discussion also helped in the development of a critical perspective from which to analyze the interview data.

The data analysis was performed by senior research staff at l'Institut Roeher Institute. The process involved the perspectives and input of the entire team of researchers.

Notes

1. L'Institut Roeher Institute, *Violence and People with Disabilities: A Review of the Literature,* for the National Clearinghouse on Family Violence, Family Violence Prevention Division, Health Canada, 1994.

2. A Project Advisory Group, which included individuals with disabilities, also provided input into the research.

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Harm's WAY:

The Many Faces of Violence and Abuse against Persons with Disabilities

We live in a violent society. And people who for one reason or another are unable to assert their own needs or their rights, or protect themselves — many of whom have a disabling condition — are susceptible to violence.
... *excerpt from* Harm's Way

Harm's Way is a ground-breaking work that will challenge everything you thought you knew or understood about violence and disability. Compassionate and thoughtful, virtually every page provides insight into the way our systemic practices, prejudices and ignorance combine to encourage or support the abuse of our most vulnerable citizens. I have encountered no other work in the area of violence and victimization that disturbed me as much. *Harm's Way* makes an outstanding contribution to the literature on interpersonal violence and abuse and is a must-read for legislators, policy makers and every person whose life is touched by people with disabilities.
Frederick Mathews, Ph.D., C.Psych.
Community Psychologist, Central Toronto Youth Services
Associate Instructor, Ontario Institute for Studies in Education

For people with disabilities, this report isn't all that shocking. What is shocking is that people outside the disabled community are so shocked at the findings. This report finally gives credence to what we've been complaining about for years.
Scott McArthur
Manager, Educational Services
Ontario Federation for Cerebral Palsy